

# Addressing Adolescent Substance Abuse: An Evaluation of Washington's Student Assistance Prevention and Intervention Services Program

2008–09 Annual Report



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State Superintendent of  
Public Instruction

**May 2010**



# **Addressing Adolescent Substance Abuse: An Evaluation of Washington's Student Assistance Prevention and Intervention Services Program**

**2008–09 Annual Report**

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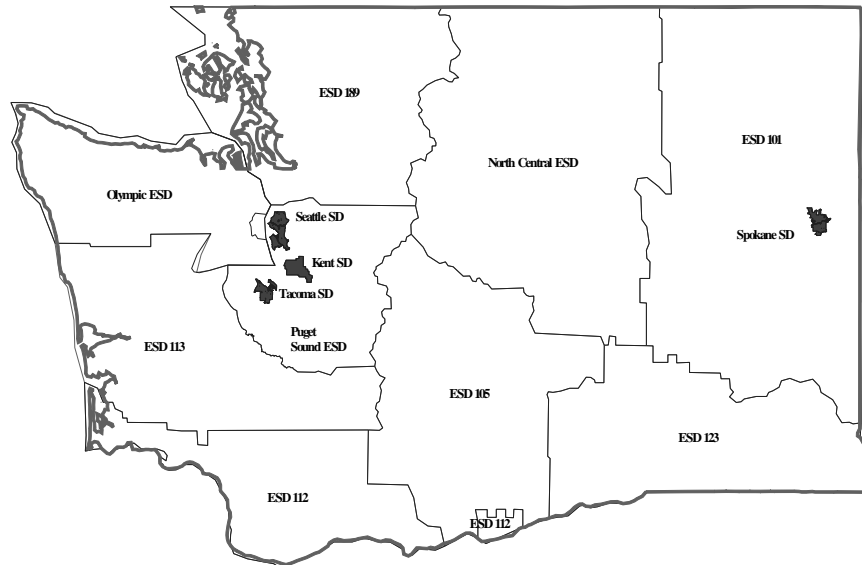
# Executive Summary

## Program Description

In 1989 the Washington State Legislature passed the Omnibus Alcohol and Controlled Substances Act that authorized state agencies to conduct a variety of programs that address the public's concern about the level and consequences of alcohol, tobacco, and other drug use. The Student Assistance Prevention and Intervention Services Program (SAPISP), operated by the Office of Superintendent of Public Instruction (OSPI) with a combination of local, state, and federal funds, places Student Assistance Professionals in schools to implement comprehensive student assistance programming that address problems associated with substance use and violence. As stated in the act (ESSHB 1793, Subpart B, Section 310, Paragraph 2), program staff are to: (a) provide early alcohol and other drug prevention and intervention services to students and their families; (b) assist in referrals to treatment providers; and (c) strengthen the transition back to school for students who have had problems of alcohol and other drug abuse.

## Where are the local programs?

Annually, program dollars are distributed to 13 local grantees—including the four largest school districts (Seattle, Tacoma, Spokane, and Kent) and nine consortia—covering virtually the entire state. Funding allocations are based on a formula that accounts for both the school enrollment and the estimated need for services of each region.



## How are students served?

Universal prevention activities typically target intact classrooms or the entire school. Examples include assistance to classroom teachers in the use of age-appropriate prevention curricula, supervision of peer leadership or pledge programs, and promotion of drug-free after-school activities. Intervention strategies involve the identification of students who are (a) at risk of initiating substance use or antisocial behavior; (b) coping with the substance use of significant others; (c) using tobacco, alcohol, or other drugs; and/or (d) developing a dependence on drugs. An array of counseling, peer support groups, social skills training, and individual and family interventions are used to address the particular needs of each student. When the severity of use requires services that

cannot be provided in the school setting, students are referred to community services such as chemical dependency treatment. In 2008–09 intervention services were provided to 18,183 students statewide.

## **Program Outcomes**

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

**Skills and attitudes.** Students participating in the SAPISP reported a strengthening in their social skills and attitudes that help them resist drug use and other inappropriate behavior. Students reported statistically significant gains on nine scales including self-concept, self-control, assertiveness, and cooperation.

**Antisocial behavior.** Students with an intervention goal of reducing antisocial behavior indicated significant reductions in five of six behaviors including truancy and fighting.

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

- Significantly more students perceived moderate to high risk in nine of ten types of substance use after the program.
- Significantly fewer students reported using alcohol, tobacco, and marijuana in the past 30 days after participation in the program. For example, 27 percent fewer students reported marijuana use and 26 percent fewer students reported binge drinking (five or more drinks) and 10 percent fewer students reported tobacco use in the past 30 days after participating.

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

- School teachers observed improved classroom performance in 85 percent of the students with unsatisfactory performance at baseline. Most of the remainder had satisfactory performance that remained unchanged.
- A group of middle and high school students who were rated as dependent on alcohol or other drugs, maintained stable GPA and attendance similar to a group referred for other reasons.

## **How can I learn more about this program?**

To learn more about the Student Assistance Prevention and Intervention Services Program, contact Dixie Grunenfelder in the Office of Superintendent of Public Instruction in Olympia, Washington, at (360) 725-6045. Detailed findings from the ongoing statewide evaluation are presented in the main body of this report. For more information about adolescent substance use in the state of Washington see *Washington Healthy Youth Survey 2008: Analytic Report* (Washington State Department of Health, 2010).

# Introduction

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Substance use continues to be a significant problem among young people. Recent survey data indicates the prevalence of substance use among students in Washington State. Of those 12th grade students who participated in the 2008 Washington State Healthy Youth Survey (Washington State Department of Health, 2010), at some time in their lives, 72 percent had tried alcohol, 44 percent had tried cigarettes, 45 percent had tried marijuana, and 11 percent had tried cocaine. Of even greater concern, 41 percent of those high school seniors reported having used alcohol in the past 30 days, and 23 percent reported having used marijuana in the past 30 days. Students also reported that they had engaged in other health risk behaviors (e.g., violence and suicide-related behaviors). These findings underscore the need for services to help students make positive decisions regarding the use of alcohol and other drugs.

To directly address concerns regarding student substance use in Washington State, in 1989 the state Legislature passed the Omnibus Alcohol and Controlled Substances Act (ESSHB 1793). One part of this act called for the creation of the Drug and Alcohol Abuse Prevention, and Early Intervention in Schools Program, now known as the Student Assistance Prevention and Intervention Services Program (SAPISP). The Office of Superintendent of Public Instruction (OSPI) allocates funds to local grantees for the purpose of placing alcohol and other drug Student Assistance Professionals in schools. (The program emphasizes schools with the highest concentrations of at-risk students and the provision of services to students in Grades 5 through 9).

Section 311 of ESSHB 1793 indicates that student assistance services are to be “directed at assisting students in kindergarten through Grade 12 in overcoming problems of drug and alcohol abuse, and in preventing abuse and addiction to such substances, including nicotine.” The SAPISP intends that Student Assistance Professionals:

- Provide early alcohol and other drug prevention and intervention services to students and their families.
- Assist in referrals to chemical dependency treatment providers.
- Support the transition back to school for students who have had problems of alcohol and other drug abuse.

The ultimate goal of the program is that the “provision of drug and alcohol counseling and related SAPISP services will enhance the classroom environment for students and teachers and better enable students to realize their academic and personal potentials” (ESSHB 1793, Section 310).

The SAPISP plays an important role in addressing Washington State’s continued concern over the economic and social costs of alcohol and other drug use and abuse. That this concern remains a priority to the state is evidenced in the report *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State*, in which the Division of Behavioral Health and Recovery (2006) presents data on the state’s progress toward

the Healthy People 2010 objectives for youth. The report shows that significant progress has been made, but current status falls short of the national goals for adolescent use of tobacco, alcohol, marijuana, and other illicit drugs.

The SAPISP also relates to Washington State's Essential Academic Learning Requirements (EALRs) for health and fitness (and to some extent the communication EALRs). The *Essential Academic Learning Requirements Technical Manual* (Washington State Commission on Student Learning, 1998) reports that the EALRs for health and fitness are based on the idea that:

An understanding of good health and fitness concepts and practices is essential for all students. Teaching our students good health and safety principles can lead to a lifetime of healthy practices, resulting in more productive, active, and successful lives. The essential academic learning requirements in health and fitness establish the concepts and skills necessary for safe and healthy living, and in turn, for successful learning.

## **Previous Evaluations**

OSPI has sponsored ongoing statewide evaluation of the SAPISP. The evaluation team has prepared annual summaries of student-level service and outcome data (see Deck [2009] for the report on 2007–08 results).

## **Methodology**

This report presents the results of evaluation activities conducted by RMC Research Corporation in collaboration with the grant coordinators and their staff, providing information about the implementation and effectiveness of the SAPISP.

**Documentation of program services.** RMC Research maintains a Web-based reporting system for SAPISP activities and outcomes. Student Assistance Professionals enter information that (a) describes universal prevention activities offered to all students; (b) describes services to students referred to selective or indicated prevention activities; and (c) assesses program outcomes for participating students. Grant coordinators and Student Assistance Professionals can run interactive reports summarizing participant characteristics, service participation, and program outcomes.

**Student outcomes.** Students referred for indicated prevention activities in Grades 6–12 complete a program evaluation questionnaire before and after participation. The questionnaire items address protective factors, school bonding, antisocial behavior, and substance use. These measures satisfy federal and state reporting requirements.

**Longitudinal follow-up of grades and attendance.** Grades and attendance are outcomes that change only over the long term. Therefore, RMC Research conducted a longitudinal study that tracked grade and attendance data over a second year for a cohort of a 20 percent random sample of students who participated in the program last year. Student Assistance Professionals obtained spring term grades and attendance for the year referred and the two following years.

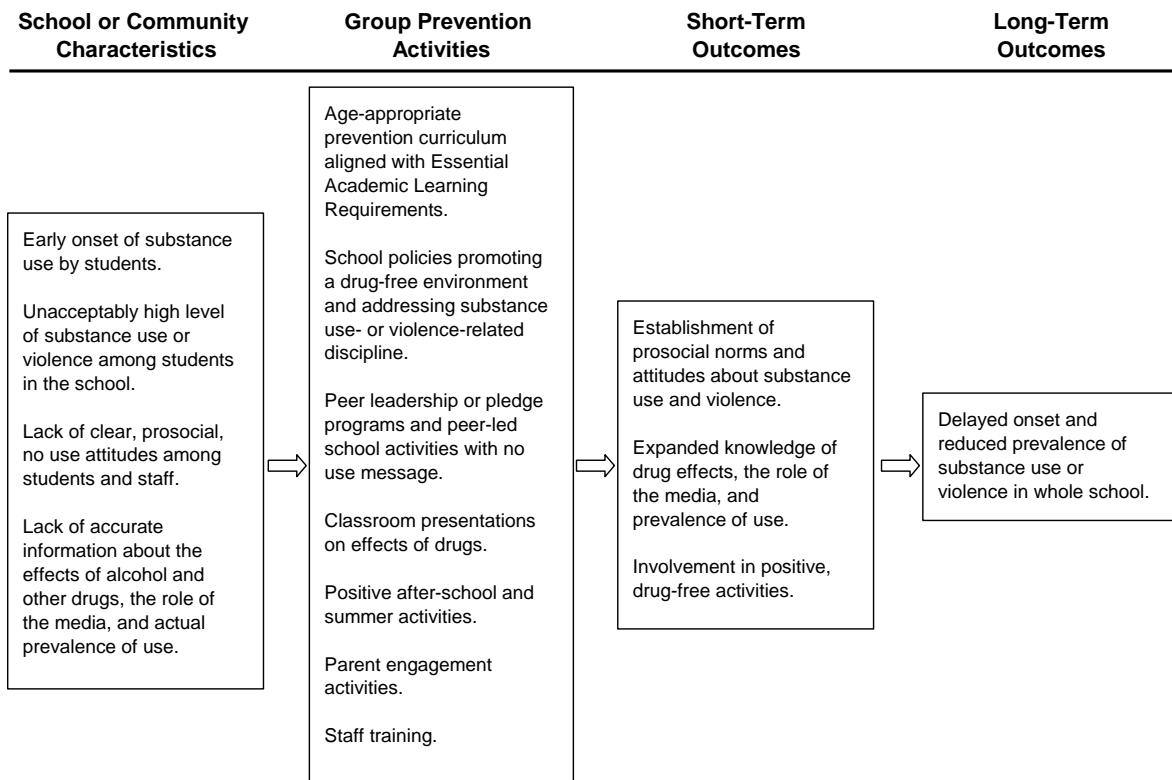
## Program Logic Model

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Comprehensive school-based substance abuse prevention programs must provide both schoolwide activities and specialized services to those identified with specific needs. The federal Center for Substance Abuse Prevention uses the term *universal prevention* to describe activities that expose all students to a prevention message and *indicated prevention* to describe services to individuals identified at high-risk for substance abuse or antisocial behavior. The SAPISP provides a continuum of student support services covering the full range of prevention strategies, including referral for treatment services. Appropriate prevention strategies include:

- Information dissemination.
- Classroom or small-group education.
- Alternative programming (e.g., drug-free dances and youth/adult leadership activities).
- Problem identification and referral (through, for example, student assistance programs).
- Community-based activities (coordinated by multiple agencies).
- School substance abuse policies.

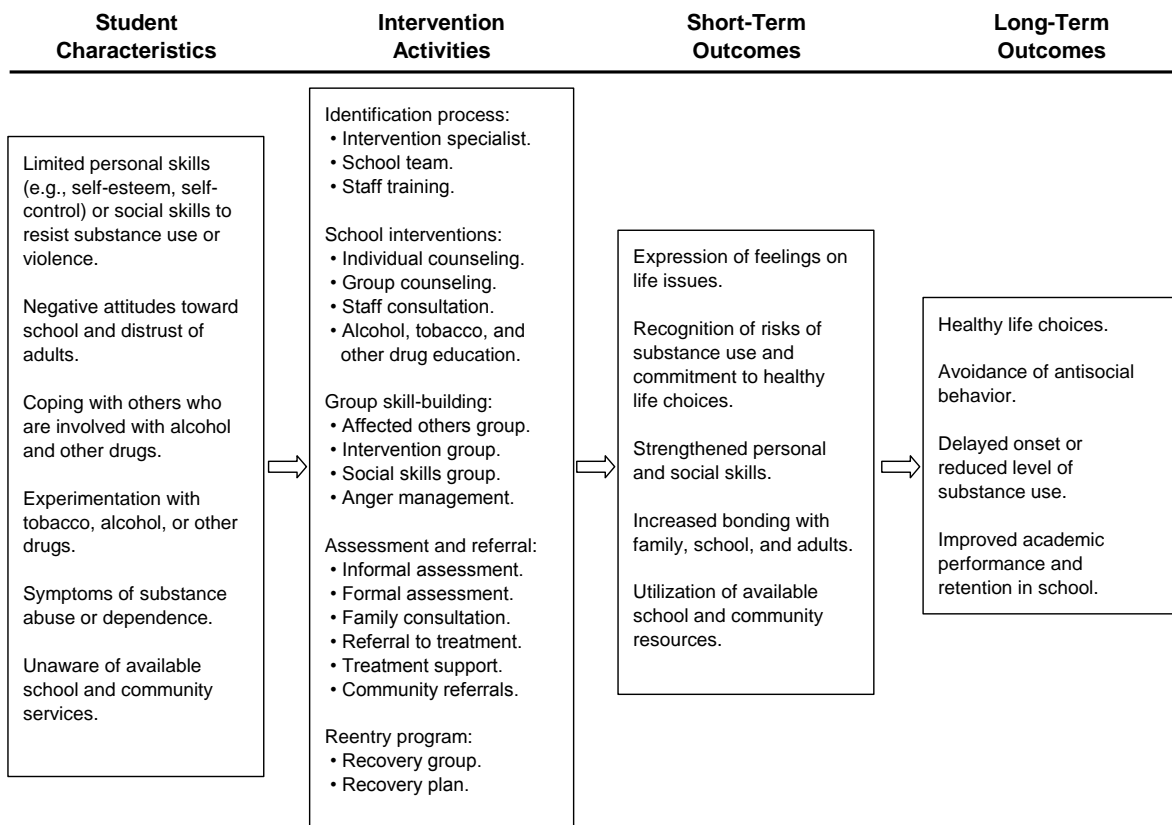
Figure 1 illustrates the general logic of universal prevention services provided by Student Assistance Professionals, linking school characteristics, program activities, and the intended short-and long-term outcomes. As this figure shows, a schoolwide needs assessment may reveal the existence of undesirable student attitudes or behaviors that suggest a need for certain prevention activities targeting the entire school or specific subgroups. If properly implemented, these activities are expected to result in certain short-term outcomes such as expanded knowledge of the effects of drugs and involvement in positive, drug-free activities. Ultimately, prevention activities promote the long-term outcome of “delayed onset and reduced prevalence of substance abuse or violence.” This logic model illustrates how the SAPISP provides prevention services to achieve particular prevention-related outcomes.



**Figure 1.** Logic model of universal prevention services provided by the program. School wide activities are initiated in response to general risk factors with the intention of reducing the overall prevalence of substance use.

Selective and indicated prevention services involve an identification and referral process, either formal or informal, to establish which students have special needs. In the SAPISP, intervention often includes the provision of individual counseling and support group services and alcohol and other drug screening, and involves the students' parents. Student Assistance Professionals refer students to community treatment agencies for alcohol and other drug assessment and treatment as necessary.

Figure 2 illustrates the logic of the indicated prevention services provided by Student Assistance Professionals. Existing student characteristics prompt the Student Assistance Professionals to try various school-based interventions or refer students to other resources. If the services are well designed and the students fully engage in them, certain short-term outcomes are expected to ensue. Ultimately, intervention services have the desired long-term outcome of helping students make healthy life choices, delaying or reducing substance use, and improving school performance. This logic model illustrates how the SAPISP provides intervention services to achieve particular intervention-related outcomes.



**Figure 2.** Logic model of selective or indicated prevention services provided to students referred to the program for substance use or other risk factors. Interventions are designed to promote skill development and attitude change leading to behavioral change.



# Program Description

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This section describes the SAPISP in relation to five evaluation questions:

- Who are the local grantees?
- Which students do local projects serve?
- What services are provided to students?
- How are students referred for service?
- What are the various service delivery models in use?

## Who Are the Local Grantees?

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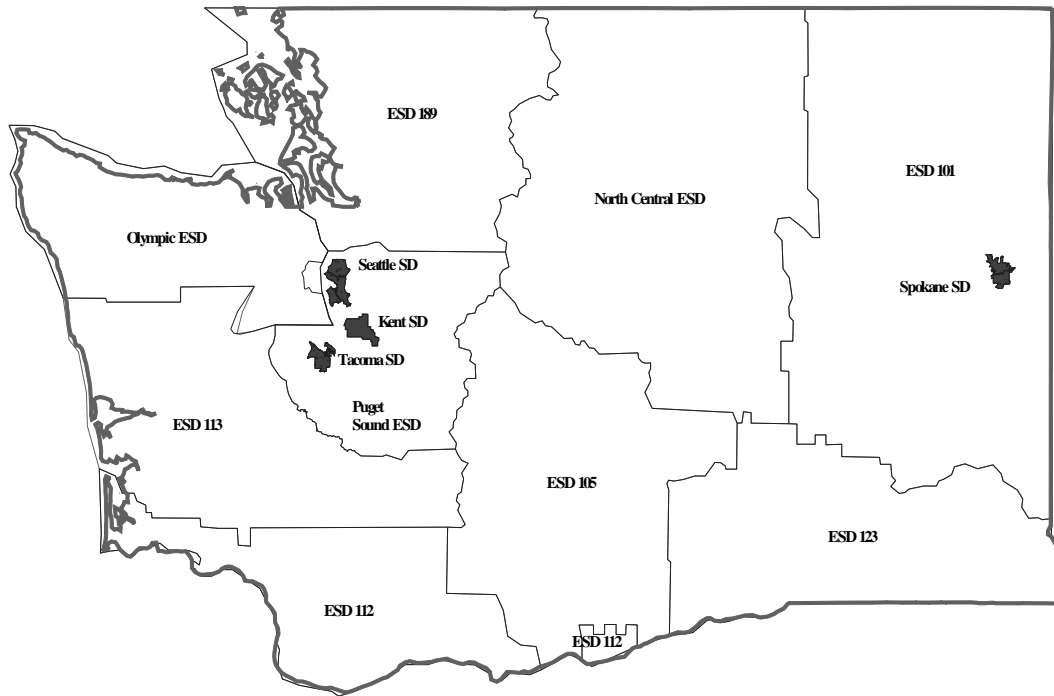
**Finding:** *Thirteen grantees implemented the Student Assistance Prevention and Intervention Services Program. The local projects served all geographic regions of the state, including three-quarters of the secondary schools.*

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**Local grantees.** Thirteen local projects provided SAPISP services to students across the state (see Figure 3). The grantees include the state’s four largest school districts (Kent, Seattle, Spokane, and Tacoma) and nine consortia:

- Educational Service District (ESD) 101 (serving Adams, Ferry, Stevens, Pend Oreille, Lincoln, Spokane, and Whitman Counties).
- ESD 105 (serving Kittitas and Yakima Counties, Royal and Wahluke School Districts in Grant County, and Bickleton and Goldendale School Districts in Klickitat County).
- ESD 112 (serving Clark, Cowlitz, Skamania, and Wahkiakum Counties and parts of Klickitat and Pacific Counties).
- ESD 113 (serving Grays Harbor, Lewis, Pacific, and Thurston Counties).
- Olympic ESD 114 (serving Kitsap County, except Bainbridge Island; North Mason School District; and Jefferson and Clallam Counties).
- Puget Sound ESD 121 (serving King and Pierce Counties and Bainbridge Island School District in Kitsap County).
- ESD 123 (serving Asotin, Columbia, Garfield, Walla Walla, Franklin, and Benton Counties and Othello School District in Adams County).
- North Central ESD 171 (serving Chelan, Douglas, Grant, and Okanogan Counties).
- ESD 189 (operated by Northwest Substance Abuse Prevention Cooperative serving Island, San Juan, Skagit, Snohomish, and Whatcom Counties; Lakewood School District is the fiscal agent).

**Figure 3.** Thirteen local projects provided services under the SAPISP. The grantees included four large school districts (shaded) and nine consortia.



Program funds are allocated to grantees according to a formula developed by OSPI that takes into account both the public school enrollment in the grantee’s service area and the need for substance abuse services in the area, as measured by indicators derived from county risk profiles (Becker et al., 1999). Prior to 1997 the funding process required grantees to compete for funding. The SAPISP now serves all geographic areas of the state and distributes grant funds more equitably.

Meeting bimonthly, the grant coordinators collaborate with OSPI staff to plan the overall direction for the program, develop strategies for coordinating the various funding streams, and share information about effective practices.

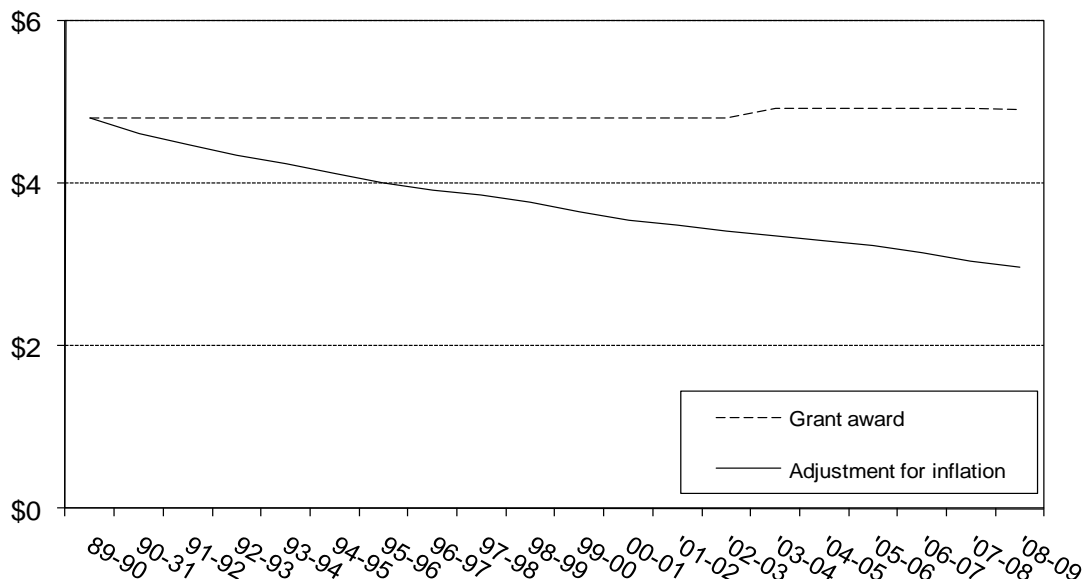
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**Finding:** *Program funding has remained flat since 1990, allowing inflation to erode 38 percent of the buying power of grant funds.*

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**Program funding.** Since its inception the SAPISP has operated with a biennial budget of about \$9 million plus local matching funds (Deck and D’Ambrosio, 2000). This budget represents approximately 50 percent of the federal Substance Abuse Prevention and Treatment Grant from Substance Abuse and Mental Health Services Administration administered by Washington’s Division of Behavioral Health and Recovery in the

Department of Social and Health Services. These allocated federal funds have remained relatively constant since 1990 with no provision for inflation. Averaged over the 2008–09 school year, a dollar was worth about \$0.61 in 1990 dollars when adjusted using the Consumer Price Index published by the United States Bureau of Labor Statistics (<http://ftp.bls.gov/pub/special.requests/cpi/cpia1.txt>). Consequently, the buying power of the program’s funding has decreased about 39 percent (see Figure 4). This decrease in buying power, in addition to the loss of other federal and state funding, has resulted in a decrease in direct services to students.



**Figure 4.** Total grant award by year adjusted for inflation. Without increased funding, the buying power of grant dollars has been eroded by inflation.

The vast majority of program funds are invested in program staff—particularly the Student Assistance Professionals, who provide direct services to students. Administrative costs account for only about 9 percent of grant expenditures. The direct cost of the program is approximately \$270 per indicated student served (excluding universal prevention activities). This cost-per-student is modest when compared to the potential societal costs of students who become involved with the criminal justice system or reliant on the public welfare system.

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**Finding:** *Over time, matching funds have provided an increasing proportion of the total program support as the buying power of the grant has declined.*

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**Matching funds.** Other funding streams contribute to local prevention efforts and should be considered part of the match. School districts receive an allocation of federal Safe and Drug-Free Schools and Communities funds, and the state Department of

Health contracts with ESDs to implement school-based tobacco prevention strategies. In addition, several local programs have received grants from the Centers for Disease Control and Prevention, the Center for Substance Abuse Prevention, the U.S. Department of Education, or other agencies to expand services or adapt special programs. Many rural grantees coordinate multiple funding streams, including local school dollars, to place specialists in a school full- or part-time. Whereas matching funds often come from federal sources, state sources include Community Mobilization Against Substance Abuse. The importance of matching funds has increased over time. In 2008–09, matching funds accounted for 63 percent of the total program support.

**Student Assistance Professionals.** Trained primarily as chemical dependency counselors or certified prevention specialists, Student Assistance Professionals are responsible for assisting students referred to the program. They are usually assigned to multiple schools on a part-time basis. With support from state and local sources in addition to the SAPISP, many are funded full-time. By November 2008 local projects had placed 259 Student Assistance Professionals in schools.

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**Finding:** *In 2008–09, 259 Student Assistance Professionals in 13 local projects provided direct services to more than three-fourths of Washington State’s secondary schools.*

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**Penetration of services.** Historically, 600 to 800 schools across Washington State receive SAPISP services annually. Consistent with the intent of the program, secondary schools are the most likely to receive services, and about three-fourths of middle schools, high schools, and alternative schools receive services annually. In contrast, only one in six elementary schools receive program services. Overall, the SAPISP serves about a third of the public schools in Washington.

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**Finding:** *In recent years Student Assistance Professionals have provided direct services to 16,000 to 20,000 students annually, despite declining resources.*

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**Number of students served.** In most years of the SAPISP, Student Assistance Professionals have provided services to 16,000 to 20,000 students. Table 1 details the level of funding, the number of participating schools, the number and full-time equivalent (FTE) of the Student Assistance Professionals, and the number of students who received direct services for each year of the program. Despite the decline in prevention and intervention specialist FTE directly supported by the grant, the number of students served has remained relatively stable due to the contribution of in-kind funds. Recently, however, reductions in grant funding has begun to have some negative impact.

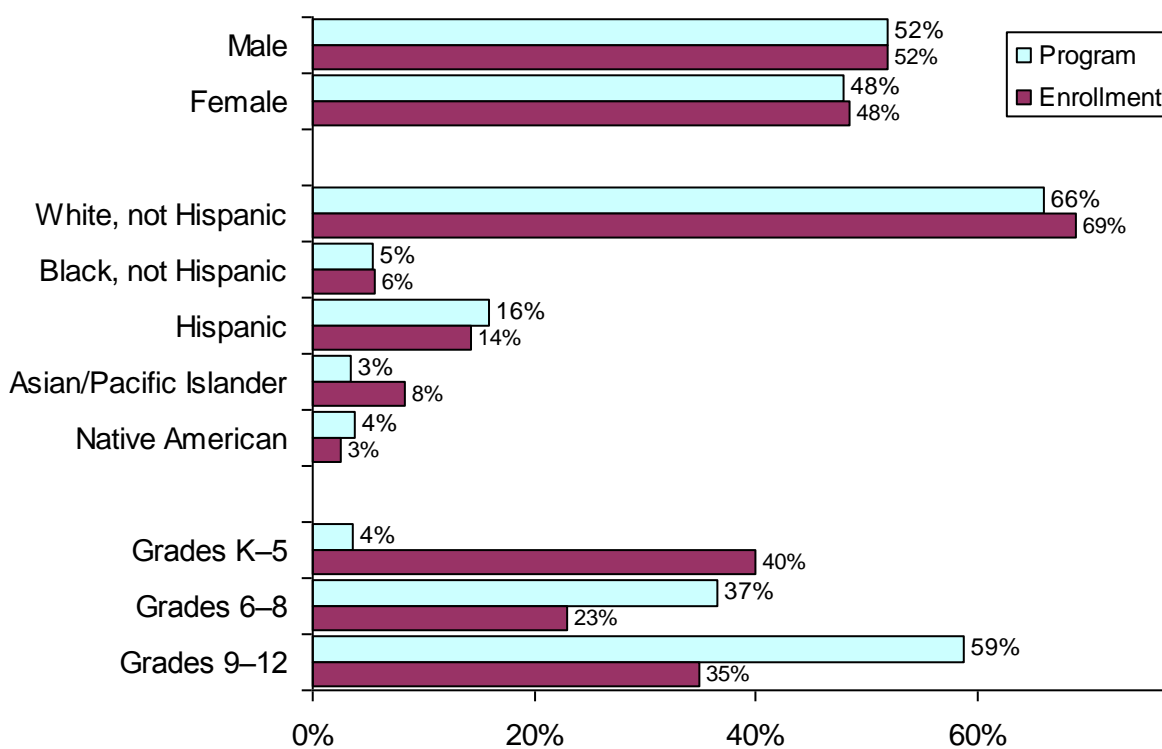
**Table 1.** Program Expenditures, Staffing, and Service Delivery 1989–2009

| Year      | Grant Award<br>(Thousands) | Grant<br>Adjusted for<br>Inflation <sup>a</sup> | Schools<br>Served | Intervention<br>Specialists |     | Students<br>Served |
|-----------|----------------------------|---|-------------------|-----------------------------|-----|--------------------|
|           |                            |   |                   | FTE                         | No. |                    |
| 1989–1990 | \$4,808                    | \$4,808   | 601               | 147                         | 198 | 11,236             |
| 1990–1991 | \$4,808                    | \$4,614   | 706               | 140                         | 206 | 21,209             |
| 1991–1992 | \$4,808                    | \$4,479   | 683               | 140                         | 241 | 21,198             |
| 1992–1993 | \$4,808                    | \$4,349   | 507               | 130                         | 245 | 19,865             |
| 1993–1994 | \$4,808                    | \$4,241   | 713               | 131                         | 214 | 18,804             |
| 1994–1995 | \$4,808                    | \$4,124   | 691               | 121                         | 205 | 19,361             |
| 1995–1996 | \$4,808                    | \$4,005   | 607               | 121                         | 204 | 17,649             |
| 1996–1997 | \$4,808                    | \$3,916   | 612               | 120                         | 206 | 18,807             |
| 1997–1998 | \$4,808                    | \$3,856   | 555               | 115                         | 222 | 19,607             |
| 1998–1999 | \$4,808                    | \$3,772   | 618               | 102                         | 242 | 21,275             |
| 1999–2000 | \$4,808                    | \$3,650   | 704               | 115                         | 268 | 21,099             |
| 2000–2001 | \$4,808                    | \$3,549   | 765               | 125                         | 292 | 22,947             |
| 2001–2002 | \$4,808                    | \$3,493   | 684               | 108                         | 305 | 23,049             |
| 2002–2003 | \$4,808                    | \$3,416   | 762               | 145                         | 333 | 22,185             |
| 2003–2004 | \$4,928                    | \$3,410   | 782               | 104                         | 294 | 18,857             |
| 2004–2005 | \$4,928                    | \$3,298   | 809               | 105                         | 278 | 16,056             |
| 2005–2006 | \$4,928                    | \$3,195   | 699               |                             | 277 | 18,446             |
| 2006–2007 | \$4,928                    | \$3,154   | 538               | 172 <sup>b</sup>            | 253 | 18,358             |
| 2007–2008 | \$4,928                    | \$3,043   | 636               | 198 <sup>b</sup>            | 257 | 16,886             |
| 2008–2009 | \$5,252                    | \$3,043   | 529               | 197 <sup>b</sup>            | 259 | 18,183             |

*Note.* Participant counts prior to 1993–94 are less reliable than data for later years. A new approach for collecting staff information was implemented in 2006 to reduce confusion and standardize recordkeeping.  
<sup>a</sup>1989–90 dollars. <sup>b</sup>FTE is now based on the total from all sources.

## Which Students Do Local Projects Serve?

**Characteristics of students served.** Consistent with the intent of the SAPISP, the majority of the students served are enrolled in secondary schools (see Figure 5). In 2008–09, 59 percent of the students served were in Grades 9–12, and 37 percent of the students served were in Grades 6–8. Over time the proportion of elementary school students (below Grade 6) served has declined to 4 percent. The program served slightly more males than females, and services were provided to members of major ethnic groups at rates that closely match the proportion of students in each ethnic group in the state as a whole, though relatively few Asian/Pacific Islander youth were served. Although the SAPISP targets students at risk for substance use and other behavioral problems, referrals to the program appear to have been equitable with respect to sex and ethnicity.



**Figure 5.** Characteristics of students served in program during 2008–09 compared with characteristics of state public school enrollment. The demographics of participating students ( $N=18,183$ ) closely parallel those of the state enrollment, with the exception that the program emphasizes services to students in secondary grades.

Students referred to the program are often involved in alcohol and other drug use. In 2008–09, 64 percent were referred for substance related issues. The goal of 67 percent of the referrals was to increase students' perceptions of the risks of drug use. Referrals

also aimed to strengthen protective factors such as decision-making (58 percent) and refusal skills (50 percent). Intervention goals for substance use included tobacco (26 percent), alcohol (37 percent), and marijuana (39 percent).

## What Services Are Provided to Students?

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**Finding:** *Student Assistance Professionals provide a variety of individual and group services that are consistent with the key components of a student assistance program. Student Assistance Professionals also make a variety of presentations to different audiences.*

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Although student assistance programs are implemented differently according to the needs and characteristics of individual schools, they exhibit several common components (Anderson, 1993; Herberg, Hughes, and Bond, 1990; Nystrom, 1992):

- **Universal prevention.** The prevention of student alcohol and other drug use is a multifaceted endeavor that includes a kindergarten through Grade 12 prevention curriculum, district policies, drug-free alternative activities, and peer leadership or pledge groups. These activities are usually directed at the entire school enrollment.
- **Identification and screening.** A process exists for identifying students who exhibit risk factors leading to behaviors that interfere with the learning process or that are harmful to the student or others in the school setting. If substance use is involved, a further screening helps determine whether some form of treatment is necessary.
- **Early intervention.** Intervention specialists help motivate students and their families to address the documented concerns. Intensive educational classes often serve as an alternative to other disciplinary actions. Other school-based interventions include counseling, parent conferences, behavior contracts, and peer support groups.
- **Referral.** Students are referred to in-school programs or out-of-school assessment, treatment, or other community-based services as needed.
- **Support services.** Support services include advocating for students who attempt to change their behavior, removing barriers that prevent students from accessing treatment or other services, and providing assistance for youth returning to school after treatment.

During the 2008–09 school year, more than 18,000 students in Washington State received direct services from intervention specialists. Although a large number of students were served in peer support group settings, the majority of the students received individual counseling. Student Assistance Professionals did, however, provide a wide variety of support groups in response to student needs. Students who have not yet begun to experiment with substances are best served by a prevention-oriented group. Students who use substances need an intervention-oriented group, and students who return from treatment need group support to maintain sobriety. Local projects typically implement one or more of the following types of support groups:

- **Prevention club.** Helps reinforce the no-use decision of students who have not yet begun to experiment with alcohol and other drugs (524 students were referred to prevention clubs in 2008–09).
- **Drug education class.** Teaches students at risk of beginning substance use about the consequences and effects of using alcohol and other drugs (2,434 students were referred to drug education classes and 1,374 students were referred to tobacco cessation or education classes in 2008–09).
- **Social skills classes.** Helps students develop the social skills necessary to resist pressure to use alcohol or other drugs and to improve interactions with peers (806 students were referred to social skills groups in 2008–09).
- **Affected others group.** Helps students learn to cope with the impact of another person’s use (2,535 students were referred to affected others groups in 2008–09).
- **Intervention group.** Challenges students who have begun to use alcohol or other drugs to consider their reasons for use and to quit using (3,883 students were referred to intervention groups in 2008–09).
- **Recovery assistance group.** Assists students in the recovery process to make the transition back to school after treatment and to develop relapse prevention skills (524 students were referred to recovery assistance groups in 2008–09).

In addition to providing support group services, Student Assistance Professionals provide violence prevention programming, conduct chemical dependency preassessments and assessments, refer students to school and community-based resources, and make contact with parents regarding student issues.

### **What Universal Prevention Activities Have Been Implemented?**

Many of the prevention activities conducted by Student Assistance Professionals target the whole school or all students at certain grade levels. Table 2 summarizes the universal prevention activities provided to students by the 13 grantees during 2008–09. The prevention framework promoted by the Center for Substance Abuse Prevention as part of the minimum data set serves as the basis of organization for the table. For each service type, the table provides the number of activities and sessions conducted, the total number of participants, and the average hours per session participants attended.

**Table 2. Universal Prevention Activities Provided to Students  
During 2008–09 by Service Type**

| <b>Activity Type</b>                   | <b>Number of Activities</b> | <b>Number of Sessions</b> | <b>Total Participants</b> | <b>Average Hours per Session</b> |
|--|-----------------------------|---------------------------|---------------------------|----------------------------------|
| <b>Awareness</b>                       |                             |                           |                           |                                  |
| Classroom presentation on ATOD issues  | 1,409                       | 1,409                     | 63,385                    | 1.33                             |
| Information dissemination to students  | 1,277                       | 1,277                     | 799,857                   | 0.79                             |
| Classroom presentations about services | 1,149                       | 1,149                     | 47,165                    | 0.81                             |
| ATOD awareness event                   | 790                         | 790                       | 341,311                   | 2.33                             |
| Community service activities           | 114                         | 114                       | 31,339                    | 2.32                             |
| <b>Curriculum</b>                      |                             |                           |                           |                                  |
| TATU peer education                    | 275                         | 521                       | 20,019                    | 1.43                             |
| Life Skills                            | 266                         | 1,009                     | 13,841                    | 1.22                             |
| Other recognized prevention curriculum | 234                         | 1,386                     | 5,817                     | 1.25                             |
| TATU leader training                   | 206                         | 382                       | 2,402                     | 1.9                              |
| Local prevention curriculum            | 116                         | 273                       | 4,256                     | 1.53                             |
| Second Step                            | 62                          | 629                       | 2,794                     | 1.17                             |
| Great Body Shop                        | 52                          | 75                        | 1,616                     | 2.43                             |
| Project Alert                          | 42                          | 316                       | 1,994                     | 1.27                             |
| END: Ending Nicotine Dependence        | 22                          | 88                        | 62                        | 1.19                             |
| NOT: No On Tobacco                     | 17                          | 74                        | 77                        | 1.03                             |
| Natural Helpers leader training        | 12                          | 16                        | 290                       | 4.28                             |
| HLAY: Here's Looking at You            | 4                           | 43                        | 137                       | 0.83                             |
| <b>Education</b>                       |                             |                           |                           |                                  |
| Prevention education groups            | 520                         | 1,894                     | 9,306                     | 1.07                             |
| Classroom series on ATOD issues        | 191                         | 454                       | 11,999                    | 1.51                             |
| <b>Peer</b>                            |                             |                           |                           |                                  |
| Prevention clubs                       | 937                         | 2,297                     | 54,412                    | 1.11                             |
| Peer leadership programs               | 202                         | 479                       | 9,847                     | 1.77                             |
| Peer mentoring programs                | 46                          | 158                       | 2,979                     | 1.37                             |
| Community prevention coalitions        | 34                          | 72                        | 1,046                     | 2.24                             |
| Peer mediation programs                | 22                          | 67                        | 406                       | 1.61                             |
| <b>Planning</b>                        |                             |                           |                           |                                  |
| Team prevention planning               | 409                         | 409                       | 9,279                     | 1.08                             |

*Note.* Curriculum, education, and peer strategies are recurring activities with multiple sessions per activity. Because awareness and planning are nonrecurring activities, the number of activities and sessions are equivalent. The participant count may be duplicated if an individual participated in more than one strategy, but the participant counts for each strategy are unduplicated counts. TATU=Teens Against Tobacco Use. ATOD=alcohol, tobacco, or other drug use.

Awareness activities generally account for the largest number of activities and participants. This category includes program outreach and information dissemination (e.g., presentations to describe program services and recruit participants), awareness-level substantive presentations (e.g., discussion of the effects of alcohol, tobacco, or other drugs in a health class), and community service activities. Curriculum and education activities typically involve greater service intensity and thus presumably have a greater impact on student behavior. Most of these activities involve multiple sessions with a structured or semistructured curriculum.

In 2008–09, most local grant coordinators reported activities in the curriculum and education domains as the core of their overall universal prevention strategy. Certainly, the results confirm that substantial effort was expended on curriculum and educational activities. The pressure to implement proven, science-based prevention curricula or programs has increased in recent years, and Table 2 shows the curricula presented during the year. Science-based curricula recognized by federal agencies as effective represent 35 percent of the reported universal prevention services provided to students in 2008–09.

Student Assistance Professionals also conduct universal prevention activities targeting families, school staff, and the general community. These strategies often focus on increasing awareness among families, school staff, and the general community of the issues and needs of students. Other strategies encompass planning, education, and curriculum. Table 3 summarizes the prevention strategies provided to families, school staff, and the general community in 2008–09. Awareness strategy services generally accounted for the largest number of activities and participants. Curriculum and education services occurred with less frequency but tended to be more time intensive for participants.

**Table 3.** Universal Prevention Activities Provided to Families, School Staff, and the General Community During 2008–09 by Service Type

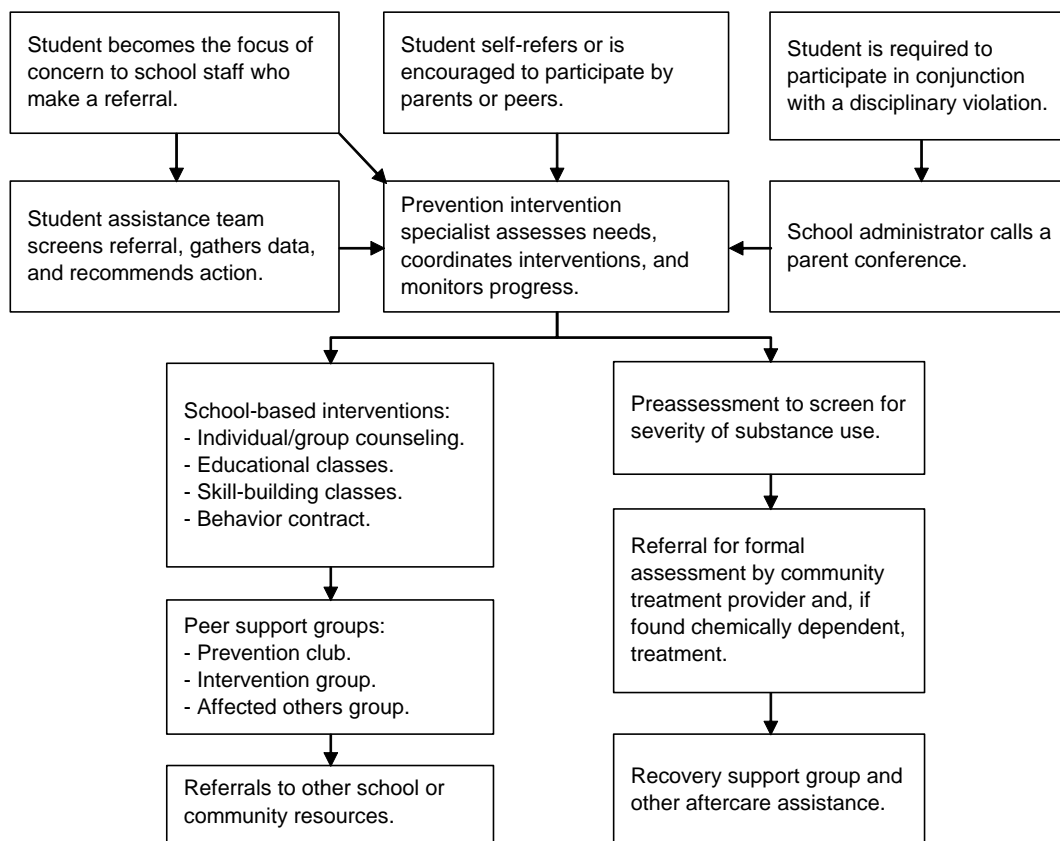
| Activity Type                                       | Target Audience | No. of Activities | No. of Sessions | Total Participants | Average Hours per Session |
|---|-----------------|-------------------|-----------------|--------------------|---------------------------|
| <b>Awareness</b>                                    |                 |                   |                 |                    |                           |
| Information dissemination to staff                  | Staff           | 1,311             | 1,311           | 86,566             | 0.65                      |
| Information dissemination to parents                | Family          | 876               | 876             | 436,734            | 1.22                      |
| Community awareness event                           | Community       | 244               | 244             | 9,791              | 1                         |
| Staff awareness presentations                       | Staff           | 215               | 215             | 73,140             | 2.98                      |
| Information dissemination to community groups       | Community       | 181               | 181             | 204,659            | 1.6                       |
| Awareness presentations to parents                  | Family          | 156               | 156             | 17,433             | 1.77                      |
| Community presentation                              | Community       | 94                | 94              | 9,712              | 2.25                      |
| Family prevention event                             | Family          | 47                | 47              | 7,671              | 2.34                      |
| <b>Curriculum</b>                                   |                 |                   |                 |                    |                           |
| Strengthening Families                              | Family          | 27                | 113             | 673                | 3.44                      |
| Staff development in presentation of curriculum     | Staff           | 54                | 73              | 399                | 2.15                      |
| <b>Education</b>                                    |                 |                   |                 |                    |                           |
| Staff development on ATOD issues                    | Staff           | 137               | 221             | 4,459              | 1.72                      |
| Parent education series                             | Family          | 46                | 138             | 1,584              | 2.44                      |
| <b>Planning</b>                                     |                 |                   |                 |                    |                           |
| Technical assistance/consultation                   | Staff           | 1,662             | 1,662           | 16,081             | 1.18                      |
| Assessment and referral services                    | Staff           | 676               | 2,170           | 6,571              | 1.09                      |
| Collaborative needs assessment                      | Community       | 351               | 351             | 6,483              | 1.41                      |
| Advisory board/coalition meeting                    | Community       | 258               | 592             | 3,527              | 1.77                      |
| Policy and procedure development and implementation | Staff           | 232               | 459             | 1,998              | 1.41                      |

*Note.* Some activities (e.g., parent education series and advisory board/coalition meetings) are recurring and have more than one session per activity. Typically, however, the numbers of activities for strategies targeting families, school staff, and the general community equal the number of sessions. ATOD=alcohol, tobacco, and other drug.

## How Are Students Identified for Indicated Prevention?

**Finding:** *Students are referred for program services by school staff, themselves, peers, or parents—sometimes as part of a disciplinary action. Student Assistance Professionals gather information about the referred students' needs and make decisions about how best to provide services.*

**Referral process.** Students are generally referred by school staff who become aware that they may be in need of help. Staff referrals include those made by school administrators in response to a disciplinary violation (less than a third of all referrals). Student Assistance Professionals often report that students self-refer to the program. This finding is an important indicator of the level of students' comfort with and trust in Student Assistance Professionals. Pursuant to a referral, information from a variety of sources is collected and a chemical dependency preassessment is conducted if one is warranted. Once this information has been collected, a decision is made regarding how best to serve the student. An array of school-based interventions or referrals to other school or community resources can be accessed. Figure 6 illustrates this process.



**Figure 6.** Typical student assistance program referral system. Multiple sources may refer students to the program. A Student Assistance Specialist coordinates or provides a range of school-based interventions or referrals for other services.

Student Assistance Professionals often indicate multiple reasons for referring students to the SAPISP and typically have a wide array of case management services at their disposal to provide directly or refer students to other school- or community-based service providers according to the type and severity of need. Table 4 summarizes the 2008–09 case management referrals. As in past years, the most common case management services were referrals for alcohol and other drug assessments, mental health care, counseling sessions with school counselors or psychologists, alcohol and other drug outpatient treatment, and community support groups. Students and their families also received numerous family-focused case management referrals. The most common such referrals were to family workers, Child Protective Services, medical and financial assistance services, living arrangement and housing services, and employment and vocation services.

**Table 4.** Case Management Referrals in 2008–09

| <b>Case Management Service</b>              | <b>Referral Rate</b> |
|---|----------------------|
| Alcohol and other drug assessment           | 33%                  |
| Mental health care                          | 25%                  |
| School counselor/psychologist               | 22%                  |
| Alcohol and other drug outpatient treatment | 15%                  |
| Community support groups                    | 14%                  |
| Alcohol and other drug counseling           | 9%                   |
| Physical health care                        | 7%                   |
| Alcohol and other drug inpatient treatment  | 5%                   |
| Family worker                               | 4%                   |
| Child Protective Services                   | 3%                   |
| Living issues                               | 2%                   |
| Other school/community referrals            | 9%                   |

The logic model for the SAPISP provides a conceptual framework for relating intervention goals to intended outcomes. Using the model as a guide, grantees identified the risk or protective factors targeted for change as outcomes using the risk and protective factor framework proposed by Hawkins, Catalano, and Miller (1992). To show the relative weight Student Assistance Professionals gave to these factors, Table 5 lists each risk or protective factor and the percentage of students with changes related to the risk or protective factor as an intervention goal during 2008–09.

**Table 5.** Intervention Goals for Students in 2008–09

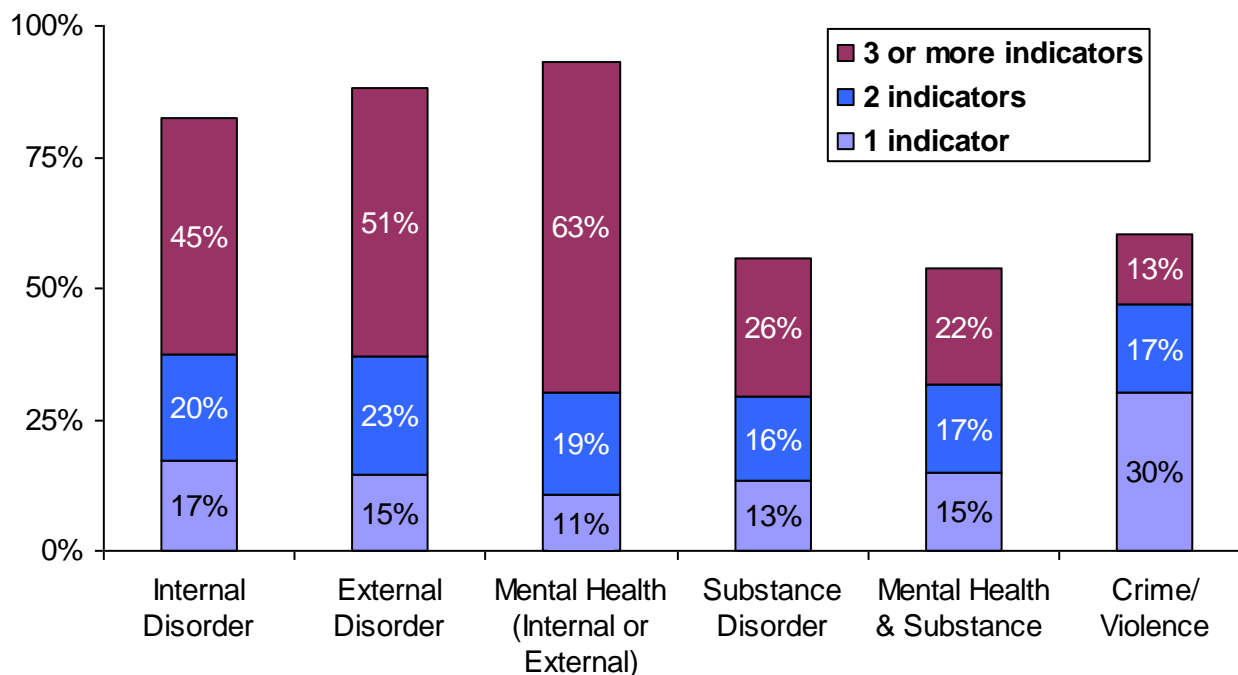
| <b>Factor</b>                               | <b>Students With Factor as an Intervention Goal</b> |
|---|---|
| <b>Strengthen Skills and Attitudes</b>      |   |
| Perceived risk of use                       | 69%   |
| Decision-making                             | 60%   |
| Refusal skills                              | 52%   |
| Awareness of social influences              | 49%   |
| School bonding                              | 45%   |
| Communication skills                        | 32%   |
| Social skills                               | 23%   |
| Self-esteem                                 | 17%   |
| Self-control                                | 17%   |
| Assertiveness                               | 17%   |
| Family bonding                              | 13%   |
| Social bonding                              | 9%  |
| <b>Reduce or Eliminate Problem Behavior</b> |   |
| Marijuana use                               | 40%   |
| Alcohol use                                 | 30%   |
| Tobacco use                                 | 27%   |
| Associate w/inappropriate peers             | 19%   |
| Anxiety, depression                         | 15%   |
| Other drug use                              | 11%   |
| Anger/uncontrolled behavior                 | 9%  |
| Truancy                                     | 9%  |
| Aggressive behavior                         | 6%  |

In terms of protective factors, 69 percent of the referred students had the perceived risk of substance use as an intervention goal. More than half had decision-making (60 percent) and refusal skills (52 percent) as an intervention goal. In terms of risk factors, the reduction or elimination of marijuana use, alcohol use, and tobacco use was an intervention goal for 40 percent, 30 percent, and 27 percent, respectively, of the students referred. In general, intervention goals emphasized the strengthening of protective skills and attitudes over the elimination of specific problem behaviors.

### Screening for Substance Use and Mental Health Issues.

During the school year, Student Assistance Professionals screened students for substance use and mental health problems requiring treatment using the short screener version of the global appraisal of individual needs (GAIN-SS; Dennis, Feeney, Stevens, and Bedoya, 2006; Dennis, Chan, and Funk, 2006). This brief instrument, developed by Dr. Michael Dennis at Chestnut Health Systems, is a carefully researched tool for identifying youth in need of formal treatment. Washington’s Division of Behavioral Health and Recovery requires that a student exhibit a minimum of three of the listed indicators to be admitted to community-based substance abuse treatment. The measure consists of subscales that assess whether a student may have internalizing disorders, externalizing disorders, substance disorders, and crime or violence problems. A score of one or two suggests a possible diagnosis; the student would likely benefit from a brief intervention. A score of three or more suggests a high probability of a diagnosis and indicates that a formal assessment and intervention are appropriate.

Figure 7 shows the results of screening 10,927 students across the state. Of these students, 26 percent met the substance abuse treatment referral criteria set by the Division of Alcohol and Substance Abuse. Another 29 percent of the respondents reported one or two substance abuse treatment indicators which suggests the need for a brief intervention in the school setting.



**Figure 7.** Results of screenings of 10,927 youth served by SAPISP grantees in 2008–09 showing the percentages of students exhibiting one, two, and three or more symptoms of each disorder.

Even more troubling was the fact that 63 percent of the students exhibited three or more internal or external mental health treatment indicators. The responses from another 30 percent of the students suggested that brief interventions, perhaps in the school setting would be appropriate. Nearly every student with a high substance disorder score also had a high mental health score. Unfortunately, age-appropriate community-based mental health treatment is very difficult to find throughout much of the state. And school-based mental health services are also rare. Given the general lack of mental health treatment options appropriate for youth statewide, this finding is particularly unsettling.

# Program Effectiveness

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The previous sections of this report described how student needs are identified and the types of services provided in response to those needs. This section examines the outcomes of the services provided to students participating in the SAPISP.

Students who enter the program have a wide range of needs. The Student Assistance Professionals must choose the appropriate interventions from an array of possible services to meet the specific needs of each student. If a student fully participates in the recommended services, certain short-term outcomes are expected to be realized first. Over time, these short-term outcomes may lead to long-term outcomes. For example, participation in a class or support group that strengthens personal or social skills may later help a student resist pressure to use alcohol and other drugs. Or, a student caught experimenting with alcohol or other drugs who is required to attend a class that promotes increased recognition of the risks of substance use may stop experimenting, or at least limit future substance use.

This student assistance model focuses attention on four basic evaluation questions: Have students, as a result of participating in the program:

- Strengthened the social skills and attitudes that help them to resist substance use and antisocial behavior?
- Abstained from engaging in antisocial behavior?
- Abstained from using alcohol and other drugs or reduced the severity of their substance use?
- Experienced increased school success?

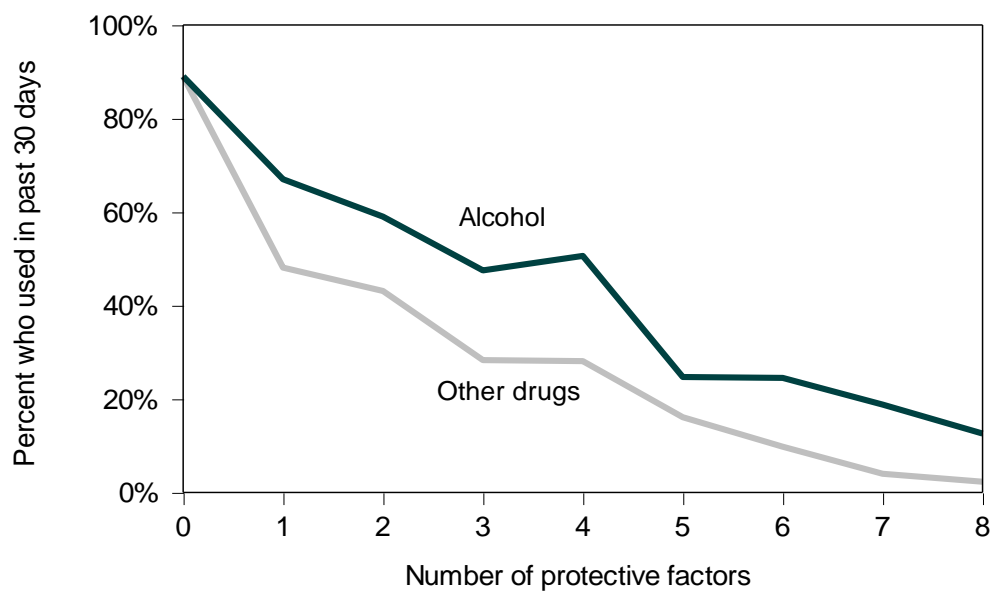
For each question, the evaluation team has pursued multiple lines of evidence to develop a more complete picture than any one data source would support. For this evaluation, the primary sources of empirical outcome data included student self-report, observations by classroom teachers, and school records. In addition, input from administrators, Student Assistance Professionals, teachers, parents, and students provide multiple perspectives.

## **Resiliency and Protective Factors**

In recent years, the prevention literature has stressed the importance of various factors in the child, home, school, and community that help young people resist alcohol and other drug use (Benard, 1991; Hawkins et al., 1992; Kumpfer, 1990). Some researchers have stressed internal factors or resiliency—the social skills and personal characteristics such as self-esteem that help adolescents resist substance use. Others have stressed external protective factors—the characteristics or functions of the school, home, and community that promote resilience. Ultimately, both internal and external factors are important (Constantine, Benard, and Diaz, 1999).

Assessments of adolescent health risk behaviors (e.g., Einspruch, Gabriel, Deck, and Nickel, 1998) have demonstrated a strong relationship between substance use and various protective factors in the individual, family, and community domains. As Figure 8 shows, students who responded positively to many of the protective factor questions tended to abstain from substance use, whereas their peers with few protective factors were far more likely to use alcohol or other drugs.

The SAPISP has increased its commitment to the risk and protective factor model, a fact evidenced by staff training that has occurred at both the state and local levels and by more explicit references to resiliency and protective factors in local project goals (e.g., Einspruch, 1997). Of the various services offered through the program, support groups are particularly oriented toward strengthening resiliency and protective factors. Fifty-five percent of the students referred to the SAPISP in 2008–09 were referred to at least one support group or class. Student Assistance Professionals have generally embraced the concepts of resiliency and protective factors because they can easily relate them to their personal experiences working with adolescents.



**Figure 8.** Relationship between the number of protective factors reported by Washington students in Grades 6, 8, 10, and 12 and the 30-day prevalence of alcohol and other drug use (Einspruch et al., 1998). Students who responded favorably on many protective factors were far less likely to have used alcohol or other drugs compared to peers who lacked such protective factors.

## **Assessing Protective Factors**

Student Assistance Professionals administer a program evaluation survey to participating students as they exited the program. The survey assesses four basic characteristics of the resilient individual: personal competence, social competence, social bonding, and caring and support. The items for the first two components were adapted from the Individual Protective Factors Index (Phillips and Springer, 1992), one of the few instruments developed to assess protective factors. The Individual Protective Factors Index was incorporated into an instrument to evaluate programs funded by the federal Center for Substance Abuse Prevention. The school bonding items were drawn from the Center for Substance Abuse Prevention's performance measures. RMC Research developed the caring and support component (Gabriel, 1996b) to assess students' perceptions of the external support and guidance provided by key adults through intervention programs.

**Personal competence.** Personal competence refers to a set of factors that involve one's personal identity. The personally competent individual is able to function effectively and make positive decisions that guide the course of his or her future. Students with strong self-esteem and a positive, achievement-oriented outlook are better able to cope with the stresses in their lives and more likely to resist substance abuse and other risky behaviors. The dimensions of personal competence include:

- Self-concept—A positive self image or feeling good about oneself.
- Self-control—The ability to control impulses, particularly antisocial impulses such as anger or violence.
- Self-efficacy—The sense that life can have a purpose and that one can effectively achieve that purpose.

**Social competence.** Social competence is defined as the ability to be responsive, caring, and flexible in social situations. Youth with these abilities will likely elicit positive responses and reinforcement from others. These social skills help students form positive interpersonal relationships and effectively handle social situations. These skills include comfort and assertiveness in social situations, confidence that one is liked and will be accepted, and a desire to contribute to social groups of which one is a part. Some prevention programs focus on specific skills to help students deal effectively with peers in social situations and resist pressure to use alcohol and other drugs or engage in risky or antisocial behavior. The dimensions of social competence include:

- Assertiveness—The ability to stand up for oneself in social situations in reasonable ways. Assertiveness is distinguished from aggressiveness in that it connotes comfort in social situations rather than hostility.
- Confidence—The belief that one is liked and will be accepted in a variety of social situations.
- Cooperation—The desire to contribute to social groups. Cooperation includes a sense of satisfaction that comes with contributing.

**Social bonding.** Social bonding refers to the degree to which one feels positively toward and is committed to basic social institutions such as family, school, and community. Bonding with family members, abstinent peers, and other adults provides positive role models and social supports. Only a measure of bonding in the school setting is included in the current instrument:

- School bonding—A positive attitude and motivation toward school, both now and in the future.

**Caring and support.** Unlike the other characteristics of the resilient individual, caring and support depends on the actions of others rather than the attitudes and abilities of the student. The dimensions of caring and support include:

- Nurturance—Support and assistance from others whom students can trust and depend on.
- Guidance—Direction and support provided by adults.

Students were asked to report how they had felt before and after participating in the program. Each item was scored on a four-point scale ranging from *very negative* to *very positive*. The school bonding items utilized a four-point scale.

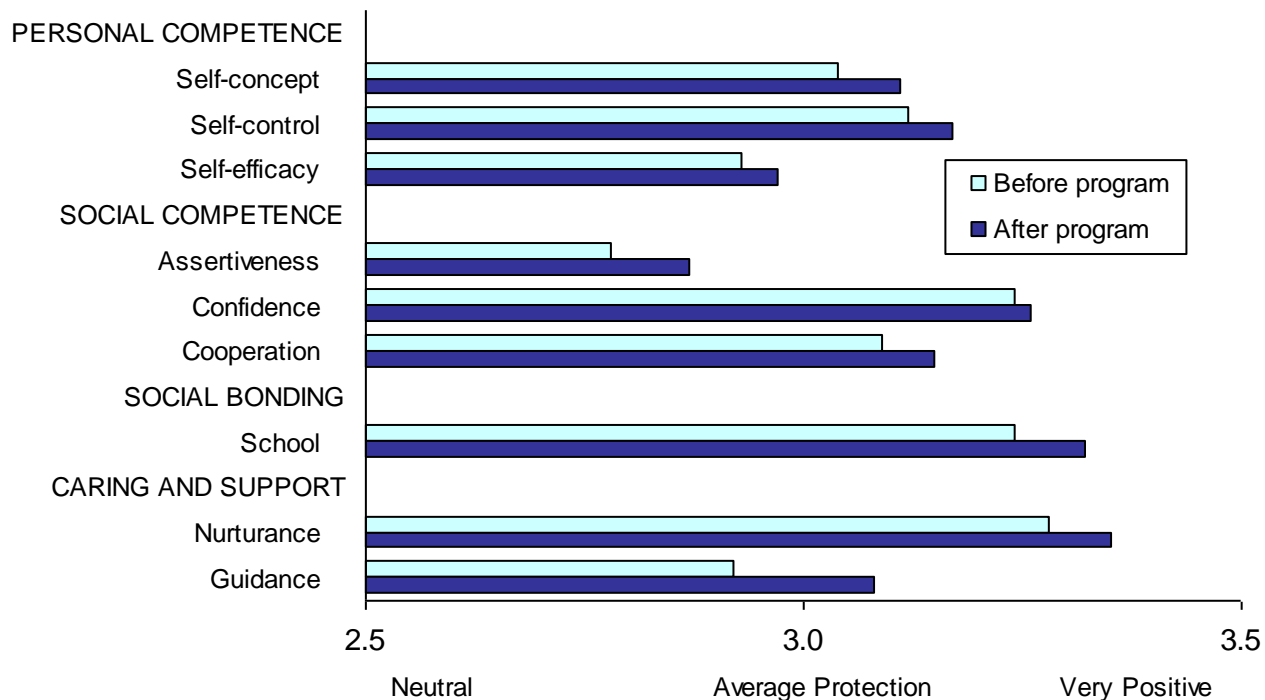
### Strengthening Protective Factors

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**Finding:** *Students reported more positive attitudes and social skills that should help them resist alcohol and other drugs after participation in the SAPISP.*

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Figure 9 displays the students' average rating on each protective factor before and after participating in the program in 2008–09. Statistically, significant gains are evident for all protective factors. In the personal competence domain, the reported gains in self-concept, self-control, and self-efficacy indicate that after participating in the program students felt better about themselves, had more control over their own behavior, and were better able to achieve their goals. These gains in social competence are encouraging because these are closely linked to the goals articulated for many of the support groups. Resilient individuals should be able to express their needs and opinions constructively, even if their needs and opinions are at odds with those expressed by their peer group.



**Figure 9.** Students who responded to the program evaluation survey reported greater protection in 2008–09 after participating in the program ( $n=8,279$ ). Student self-ratings for all protective factors were significantly higher after program participation.

Students also reported improvement in bonding with their school after participation in the program. In past interviews with participating students, many reported that the assistance they received from the Student Assistance Professionals helped them reconnect to their school and strengthened their resolve to do well in school. It should be noted that in prior years, little or no change was observed on this scale.

Improvement in the nurturance and guidance domains suggests that more students believed they were receiving constructive support from adults in the school setting than before they participated in the program. In past interviews with participating students, appreciation for the support and guidance provided by the Student Assistance Professional was a pervasive theme.

Max (4<sup>th</sup> grade) and Paul (1<sup>st</sup> grade) moved to Washington from Montana to live with their father. Mom could not “handle” the boys anymore. She and her live-in boyfriend were substance users and at times had physically abused the boys. Dad, on the other hand, had not been in the boy’s life much since Paul was born. The SAPISP Student Assistance Professional began meeting with the boys one-on-one from the beginning. Max was a very angry boy. He hated school, had a gang type mentality, picked on younger students, was a bully at school and on the bus, confronted adults, and had serious anger toward women and women in authority. Paul was also an angry boy. He was following his brother and participating in bullying behavior. He would overreact when he would get in trouble, yell at adults, and was defiant in and out of the classroom. The Student Assistance Professional met with the boys weekly, strategizing with dad, and securing counseling for the boys as well as family counseling. Dad took the boys to counseling for the rest of the school year.

At the beginning of their 5<sup>th</sup> and 2<sup>nd</sup> grade school year; each boy was in “rare” form. Dad had dropped the counseling. By October, the boys were each on the lowest level of the discipline system and Max had already been in In-School Suspension. The Student Assistance Professional continued to meet with the boys and work with dad for the rest of the school year with little to no change in attitude or behavior.

This year Max entered middle school and Paul enters 3<sup>rd</sup> grade. Dad and the boys are following recommendations from the Student Assistance Professional and the outside counselor. Each boy is succeeding beautifully. The boys are on the HIGHEST/best level on our discipline system. They are able to participate in all school activities. They are turning in their homework, have positive friendships, positive interactions with adults, and appropriate behavior with other students and even initiate conversations with teachers and the principal. Max even has a 2.6 GPA! Each week Max brings the Student Assistance Professional his grade check so she can see how well he is doing, and then they skip arm and arm down the hall to celebrate!

## **Attitudes About Substance Use**

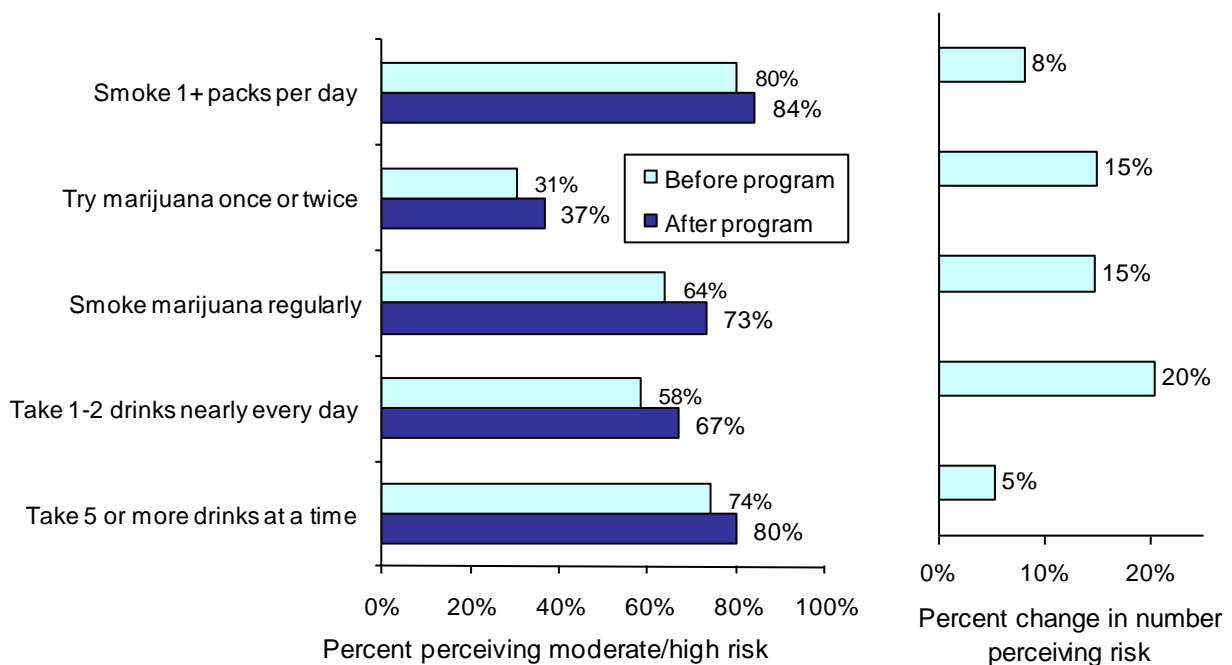
Attitudes about substance use are another important risk factor associated with adolescent substance use. In particular, state and national studies (Einspruch, Deck, Nickel, and Hyatt, 2001; Johnston, O’Malley, and Bachman, 1994) have shown that the perceived risk of substance use is highly correlated with substance use. In fact, perceived risk appears to be a leading indicator of national changes in substance use among high school seniors. The rise in illicit drug use during the early 1990s was foreshadowed by a decline in perceived risk, suggesting an erosion of antidrug attitudes and norms among adolescents (Gabriel, 1996a).

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**Finding:** *After participating in the program, more students reported that each of five forms of substance use involved moderate to great risk.*

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Students who completed the program evaluation survey when exiting the program responded to four questions regarding the perceived risk of specific types of substance use. Figure 10 shows the percentages of students who reported perceiving moderate or great risk related to five forms of substance use—heavy smoking, experimenting with marijuana use, regular marijuana use, daily drinking, and binge drinking (five drinks at one time)—before and after participation in the program. The figure also reports the net percentage increase in the number who reported moderate to great risk. Only students with an intervention goal of correcting perceived risk were included in the analysis.



**Figure 10.** More students reported moderate to great risk of 5 types of substance use after participating in the program in 2008–09 ( $n = 8,113$ ).

Even before participating in the program, most students (80 percent) recognized the risk associated with smoking a pack or more a day, smoking marijuana regularly (64 percent), binge drinking (74 percent), and daily drinking (58 percent). In contrast, relatively few believed that experimenting with marijuana was risky (31 percent). After participating in the program, significantly more students reported risk related to each of the five behaviors. For example, the percentage who reported moderate to great risk in experimenting with marijuana once or twice increased from 31 to 37 percent—an increase of 6 percentage points, which represents a 20 percent improvement over the baseline. These differences, though modest, were statistically significant.

Melinda is a 17 year old high school student that was experiencing social conflicts and angry outbursts at school. Her friends came to the SAPISP Student Assistant Professional with concerns that she was cutting herself extensively. Melinda was also smoking cigarettes, marijuana, and drinking regularly. Melinda met with her Student Assistance Professional individually and eventually ended up in a “Family Concerns” educational support group. She was the “good child” in her family. She made a point to never ask for anything from her parents, to get good grades and perform well in school. Eventually, her real feelings of being unseen, neglected, and not getting her needs met became very painful. She started using substances, which worked for a while to supply the “feel good” chemicals to her brain. Eventually, she had to use more frequent, stronger substances, and added cutting as a means to feel good. To add to her problems, her father was an active marijuana smoker and marijuana was available to her at home. With group support she managed to quit smoking marijuana and cutting herself. She was also referred to outside mental health counseling. She now has a new set of friends, is exploring her musical talents, performs in the school plays, and is a published poet. She knows her struggles are not over, but she has learned so much and now presents herself as a proud, confident, and compassionate young woman.

## **Substance Use**

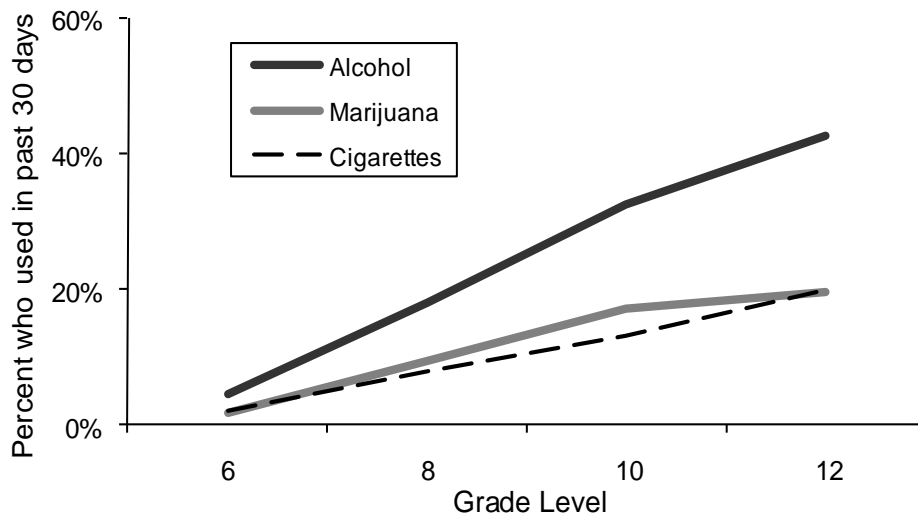
Curbing substance use among adolescents is the central purpose of the SAPISP. Students come to the program in various stages of substance use. Some students have not yet used alcohol and other drugs but exhibit characteristics or behaviors that put them at risk of starting soon. Others are beginning to experiment with cigarettes, alcohol, and marijuana. Still other students have progressed to heavier levels of use and a few have already developed a dependence on alcohol or other drugs. This subsection focuses on the substance use-related behaviors and attitudes of the students referred to the program, with a focus on the program’s impact on students entering with different levels of use.

The evaluation team examined several indicators of substance use. Thirty-day use—the percentage of students who reported using a substance at least once during the past 30 days—indicates how many students are currently using a substance, but does not distinguish the level of use. Thirty-day use works well in assessing reductions in experimental substance use but is less sensitive to reductions in the level of use among heavy substance users.

### **Substance Use in the Past 30 Days**

Typically, a developmental sequence is present in the evolution of substance use and other risky behaviors among adolescents (Jessor and Jessor, 1978). The prevalence of substance use increases as students grow older, first with so-called *gateway drugs* such as alcohol, tobacco, and marijuana. Early onset of the use of these drugs is one of the strongest predictors of adolescent substance abuse and a variety of other behavior

problems. Figure 11 illustrates the relationship between grade level and substance use observed in the results of a recent survey of adolescent health behaviors in Washington (Einspruch, 2005). Although these data are cross-sectional (i.e., simultaneous administration of the survey to students at four grade levels) rather than longitudinal (i.e., administration to the same students at different points in time), Figure 11 suggests that the older students are usually more likely to use alcohol, tobacco, and marijuana. Thus over the course of a school year, it is reasonable to expect an increase in the proportion of students using alcohol or other drugs without some intervention by the school, community, or home.



**Figure 11.** Statewide substance use by grade level. Washington public school students in 2004 who reported using alcohol, tobacco, or marijuana in the past 30 days increased by grade level (Einspruch, 2005). This finding suggests that without special intervention, substance use tends to increase with age.

### Any Substance Use

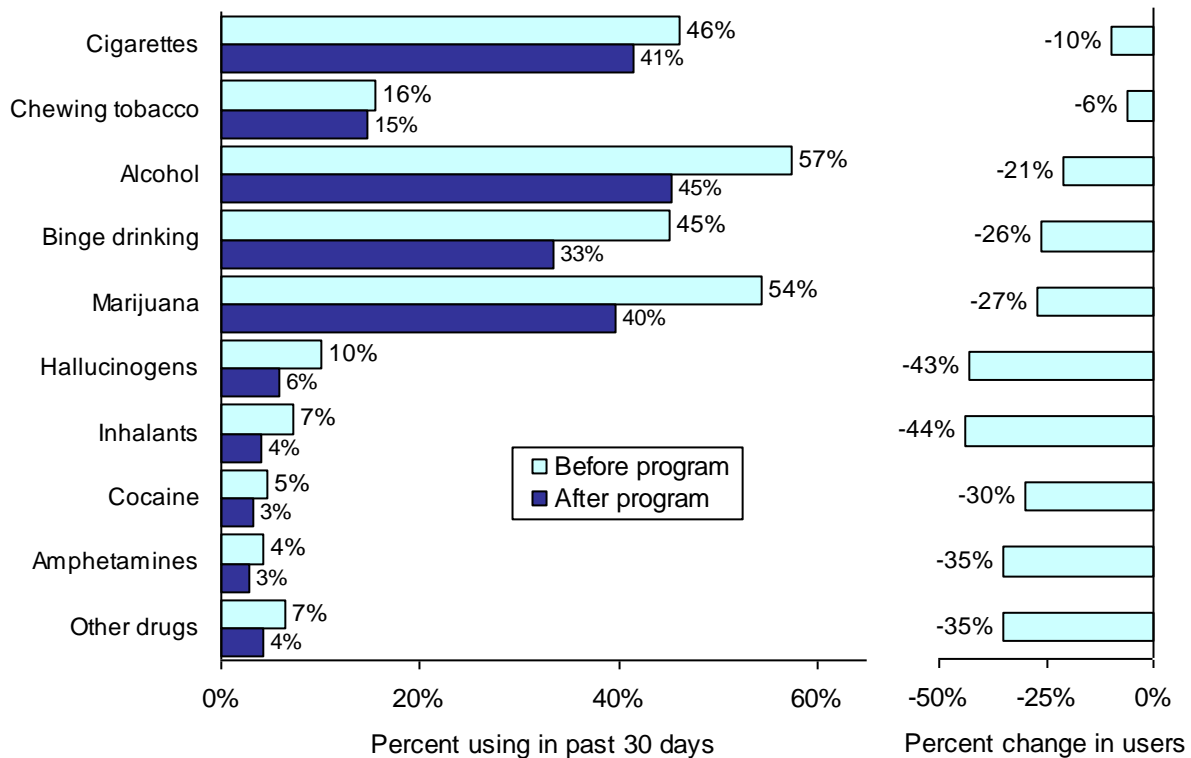
The program evaluation survey asks students questions about their substance use before and after program participation. The survey administration guidelines direct Student Assistance Professionals to ask students in Grades 6–12 with whom they had had at least three contacts to complete the survey when the students stop participating in the program or at the end of the school year, whichever comes first. In 2008–09 more than 12,000 students met the survey administration guidelines. Of these, 10,809 students completed a pretest and 8,449 completed both a pretest and posttest.

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**Finding:** *In 2008–09, significantly fewer students with an intervention goal of reducing substance use reported having used alcohol, tobacco, and other drugs in the past 30 days after participating in the program.*

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A majority (60 percent) of the students referred to the SAPISP in 2008–09 had an explicit intervention goal of delaying or reducing the use of illegal substances. Without some type of intervention, the prevalence of substance use for this group would be expected to increase during the school year. Figure 12 shows the prevalence of use for various substances before and after participating in the program among students with a substance use intervention goal for at least one substance. When exiting the program, significantly fewer students reported having used each substance in the past 30 days compared to when they entered the program. The net percentage decrease in the number of substance users is illustrated on the right.



**Figure 12.** Fewer students with an intervention goal of reducing substance use reported having used each substance in the past 30 days after participating in the program in 2008–09 ( $n=5,252$ ).

The results show a modest reduction in cigarette use but not for smokeless tobacco: 10 percent fewer students reported smoking cigarettes after program participation. Tobacco prevention and intervention receive extra attention due to tobacco settlement funds, and even a small decline in tobacco use should be viewed as positive given the difficulties youth experience trying to quit.

A greater reduction, 21 percent, occurred for alcohol use following participation in the program. Larger reductions were also evident for binge drinking (consuming five or more drinks at one time) and marijuana use. Whereas 45 percent reported binge

drinking in the 30 days before the program, only 33 percent reported binge drinking after the program—a 26 percent reduction in the number of students reporting this particularly risky pattern of alcohol use. Also striking is the 27 percent decline in the number of marijuana users; whereas 54 percent reported use in the 30 days before participating in the program, 40 percent reported use after the program. This finding is particularly important because marijuana is now the primary drug used by youth entering substance abuse treatment.

All of the differences in substance use are statistically significant, except for smokeless tobacco, which suggests that the reductions are not attributable to chance alone. Although even small differences can be statistically significant with such a large sample of students, these reductions are moderately large. Furthermore, as Figure 12 suggests, without intervention 30-day use rates would have reasonably been expected to increase rather than decrease during the school year. The rate of substance use did, however, increase by grade level. Table 6 shows the substance use reported by students in Grades 6–8 and Grades 9–12. As expected, the older students used more of most substances, but a similar decline in use following program participation was observed for both groups.

**Table 6.** Substance Use Among Students in Grades 6–8 and Grades 9–12 in 2008–09

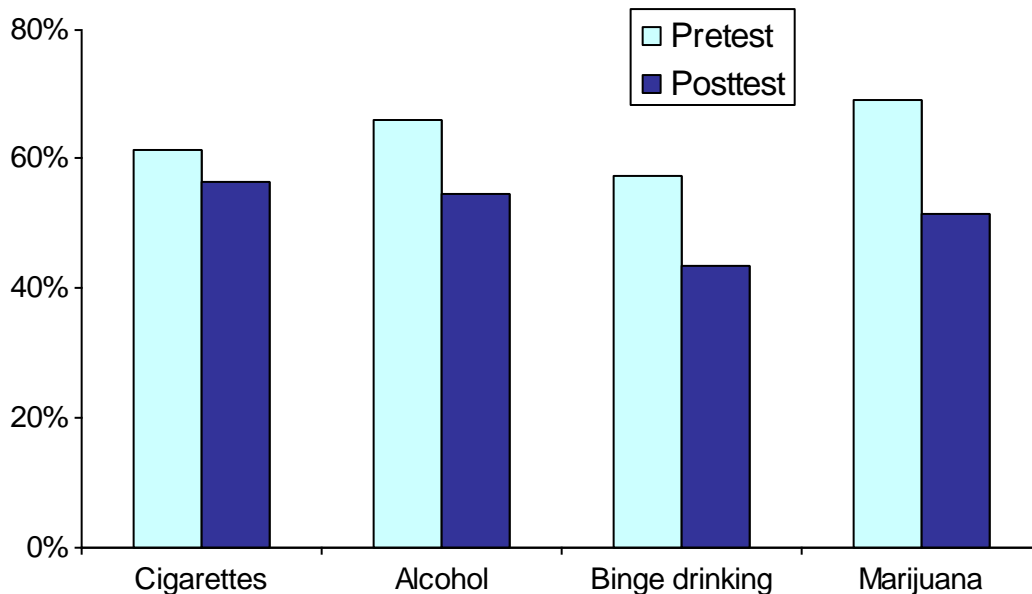
| Substance         | Grades 6–8<br>(n = 2,432) |          |        | Grades 9–12<br>(n = 2,814) |          |        |
|-------------------|---------------------------|----------|--------|----------------------------|----------|--------|
|                   | Pretest                   | Posttest | Change | Pretest                    | Posttest | Change |
| Cigarettes        | 40%                       | 34%      | -15%   | 51%                        | 48%      | -7%    |
| Smokeless tobacco | 11%                       | 10%      | -6%    | 20%                        | 18%      | -6%    |
| Alcohol           | 53%                       | 42%      | -22%   | 61%                        | 48%      | -21%   |
| Binge drinking    | 40%                       | 30%      | -25%   | 50%                        | 37%      | -26%   |
| Marijuana         | 51%                       | 39%      | -25%   | 57%                        | 41%      | -29%   |
| Hallucinogens     | 9%                        | 6%       | -38%   | 11%                        | 6%       | -47%   |
| Inhalants         | 10%                       | 5%       | -45%   | 5%                         | 3%       | -41%   |
| Cocaine           | 4%                        | 3%       | -18%   | 5%                         | 3%       | -37%   |
| Amphetamines      | 4%                        | 3%       | -28%   | 4%                         | 3%       | -40%   |

*Note.* The students included in this analysis had an intervention goal of reducing substance use. Pretest and posttest are defined as the past 30 days before and after, respectively, participation in the program.

Diane, a middle school student, was referred to the SAPISP Student Assistance Professional by the school counselor. During the initial screening she reported smoking OxyContin and marijuana daily. She informed the Student Assistance Professional of her history of abuse by her father and brother, and her subsequent placement in foster care. Since her initial placement she has been placed in ten foster homes, kicked out of each one because of drug use and inappropriate sexual behavior. She was finally placed back in her father's home, but has spent weeks at a time living on the streets. After being picked up by police at a friend's house "high" on pills, she was sent to the local juvenile detention facility. From there, she entered inpatient chemical dependency treatment. When she returned home after completing treatment, the Student Assistance Professional worked with her to identify a new group of supportive friends, developed a plan for keeping her in school, and worked to keep her healthy and free from drugs. Diane understands there is a tough road ahead, but is moving in the right direction.

### **Heavy Substance Use**

Grant coordinators have inquired whether the results are positive for students with particularly high levels of substance use. To address this inquiry, the evaluation team used the substance disorder scale of the GAIN-SS to identify students who exhibited at least three of the five treatment indicators. Figure 13 demonstrates that the percentages of these students who reported using tobacco, alcohol, marijuana, and binge drinking in the past month declined notably over the course of the year. The frequency of use was also examined. The change was small for cigarettes but students reported moderate reductions in the frequency of drinking, binge drinking, and marijuana use.

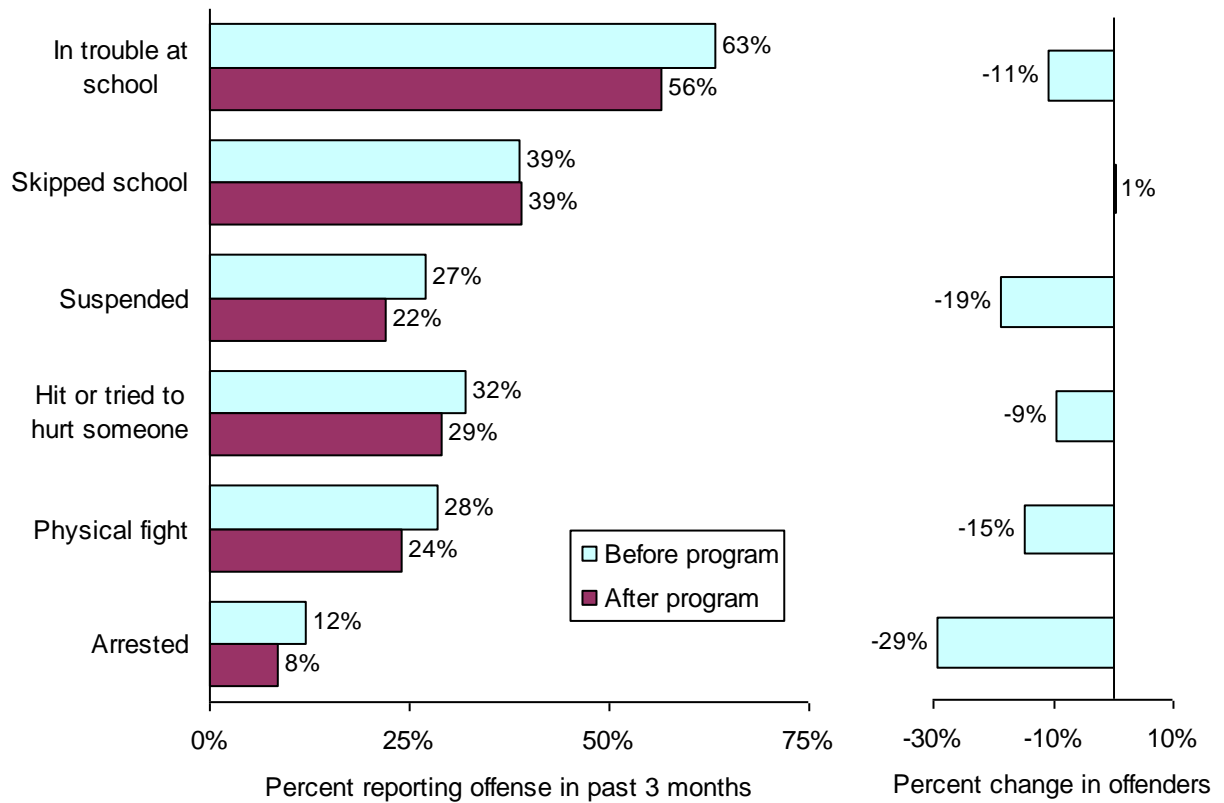


**Figure 13.** Substance use among students meeting criteria on GAIN-SS. Students exhibiting three or more treatment indicators on the GAIN-SS substance disorder scale were less likely to use substances in the past 30 days after participating in the program in 2008–09 ( $n=1,787$ ).

### Antisocial Behavior

Antisocial behavior can be disruptive to other students in the class and can be a barrier to learning for the student exhibiting antisocial behavior. Early engagement in antisocial activities is a risk factor for subsequent substance use and other problems. The level of public concern over antisocial behavior has increased dramatically in recent years, especially following various shooting incidents and gang violence in schools across the country.

Students with a behavioral intervention goal who completed both the pretest and posttest in 2008–09 ( $n=3,290$ ) were less likely to report antisocial activity in the past 3 months after participating in the program (see Figure 14). A statistically significant reduction in the prevalence of each antisocial behavior, except skipping school, is evident after program participation. For example, the percentage of students who reported getting in trouble at school in the past three months decreased from 63 percent to 56 percent, and the percentage of students who reported being involved in a physical fight in the past three months decreased from 28 percent to 24 percent after participating in the program.



**Figure 14.** In 2008–09 fewer students referred for behavioral issues reported engaging in specific antisocial behaviors during the past three months after participating in the program ( $n=3,290$ ).

To illustrate the importance of these changes in another way, Figure 14 also indicates the net percentage decrease in the number of offenders for each behavior. For example, the decrease in the percentage of students who reported getting in trouble in school represents a 11 percent reduction in the number of offenders. Likewise, the net reduction in physical fighting was 15 percent.

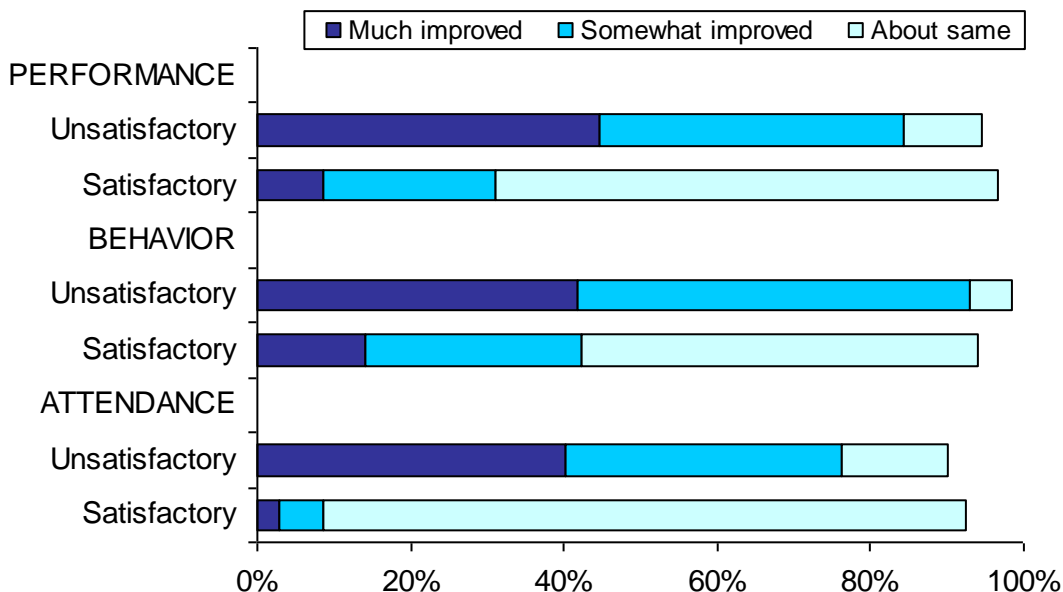
## **School Success**

Research has shown that low grades, poor attendance, disruptive school behavior, and low commitment to school are risk factors for substance use and other risky behaviors (Hawkins et al., 1992). These factors are among the most common reasons for referring students to the program. The relationship between substance use, program participation, and school performance is, however, complex. Local projects typically address substance use or other risk factors thought to be the cause of poor school success and usually do not provide direct academic assistance. Students may continue to do well in school despite involvement with alcohol and other drugs, but as the severity of substance use increases academic performance and attendance can be seriously impaired. Furthermore, the process of addressing their own substance use or dealing with issues stemming from a family member or close friends' substance abuse may have a temporarily negative effect on students' grades and attendance. In fact, participation in treatment or support groups during the program often takes students out of the classroom. School success should be viewed as a long-term rather than short-term outcome of the program.

This evaluation considered the impact of the SAPISP on three school success outcomes: academic performance, attendance, and school behavior. Grades and attendance data were obtained from school records for middle and high school students. Teacher ratings were collected from elementary and alternative schools where grades were unavailable.

## **Teacher Ratings**

For students in elementary and alternative schools, grades and attendance are typically unavailable, but a primary teacher typically has daily contact with the students. In these schools, the Student Assistance Professionals asked the classroom teachers to rate changes observed in the students' classroom participation, attendance, and behavior on a five-point scale from *much worse* to *much improved*. Figure 15 shows the teachers' ratings.



**Figure 15.** Teacher ratings for 491 students in elementary or alternative schools with initially unsatisfactory class performance, behavior, or attendance in 2008–09 generally showed improvement during the year. Some students rated as satisfactory before the program also improved.

Teachers rated classroom performance as *much improved* for 45 percent and *somewhat improved* for 40 percent of students with unsatisfactory performance before participating in the program. At least some improvement was also observed for 21 percent of those rated as having satisfactory performance before participating. Teachers rated behavior as *much improved* for 42 percent and *somewhat improved* for 51 percent of students with unsatisfactory performance before participating in the program. They rated 42 percent of the students with satisfactory performance before participating as improved. Teachers rated attendance as *much improved* for 40 percent and as *somewhat improved* for 36 percent for students with unsatisfactory attendance prior to participation in the program. Of those with satisfactory attendance before the program, 9 percent improved.

### Grades and Attendance

The evaluation team conducted a longitudinal study to examine grades and attendance over a longer period of time. The team drew a 20 percent random sample of students referred to the program during the 2005–06, 2006–07, and 2007–08 school years. The Grade Point Average (GPA) and attendance data for the spring prior to referral to the program served as a baseline measure of academic success prior to program participation. GPA and attendance data from spring term of the next two years served as follow-up measures of academic success. Students were excluded from the sample if they were not in a grade level that would allow obtaining three data points from the same school or if their status at the end of the school year suggested that they had moved. Despite these precautions, it was possible to obtain complete GPA and

attendance data on only about a third of the sample. Students moving or transferring, staffing changes at that school, and difficulties in finding the requested data were the most common reasons for incomplete data.

The evaluation team expected that students whose substance use was more severe at program intake would have poor grades and attendance and would, with intervention, improve more over the long term than would students whose substance use was less severe at intake. Furthermore, students with higher levels of program participation would achieve greater improvements in academic success than would students with lower levels of program participation. Statistical analyses by level of program participation generally supported these hypotheses.

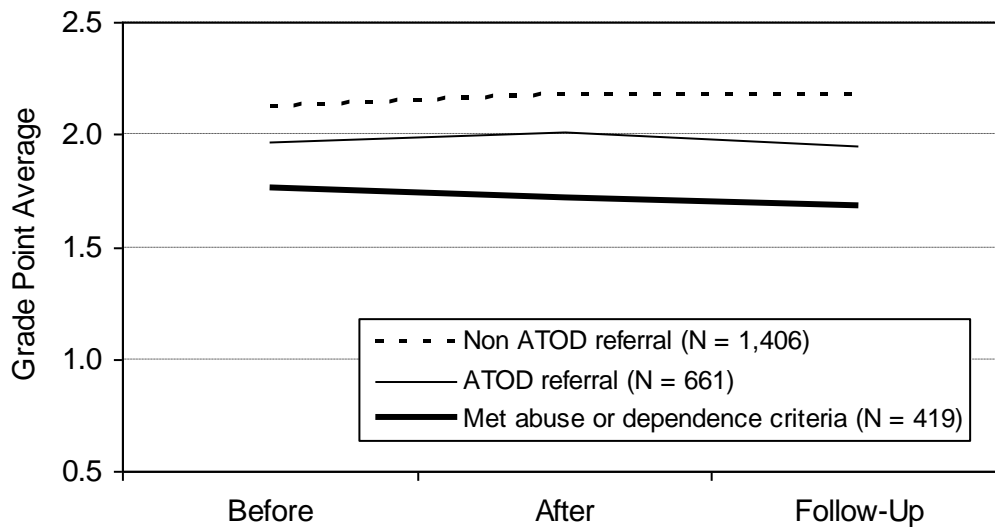
Joe is a junior in high school and living with his chemically affected family. When he was referred to the SAPISP Student Assistance Professional, he was facing the burden of drug-related legal charges, as well as school suspension. After an initial screening by the Student Assistance Professional, he was referred onto chemical dependency treatment. The Student Assistance Professional monitored his progress in treatment and was able to provide transition back to school once he completed his inpatient treatment. Upon his return to school, he attended a weekly recovery support group facilitated by the Student Assistance Professional. After a great deal of work, Joe was experiencing successes socially, emotionally, and academically. He was just 2 weeks shy of a year without any drug or alcohol use and was carrying close to a 3.5 GPA while taking double classes needed to catch when he had a “slip” with marijuana at school and was facing expulsion. Instead of giving up, Joe told the assistant principal that he wanted to talk with the Student Assistance Professional. The Student Assistance Professional worked with Joe and school administrators to develop a plan to get Joe back on track towards graduation and college. Joe continues to share his story in freshman health classes with charisma and authenticity. His personal and academic success has allowed other students to evaluate their own destructive decisions.

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**Finding:** *Results of a longitudinal study suggest that students served during the 2005–06, 2006–07, or 2007–08 school years exhibited little change in grades by the end of the following school year.*

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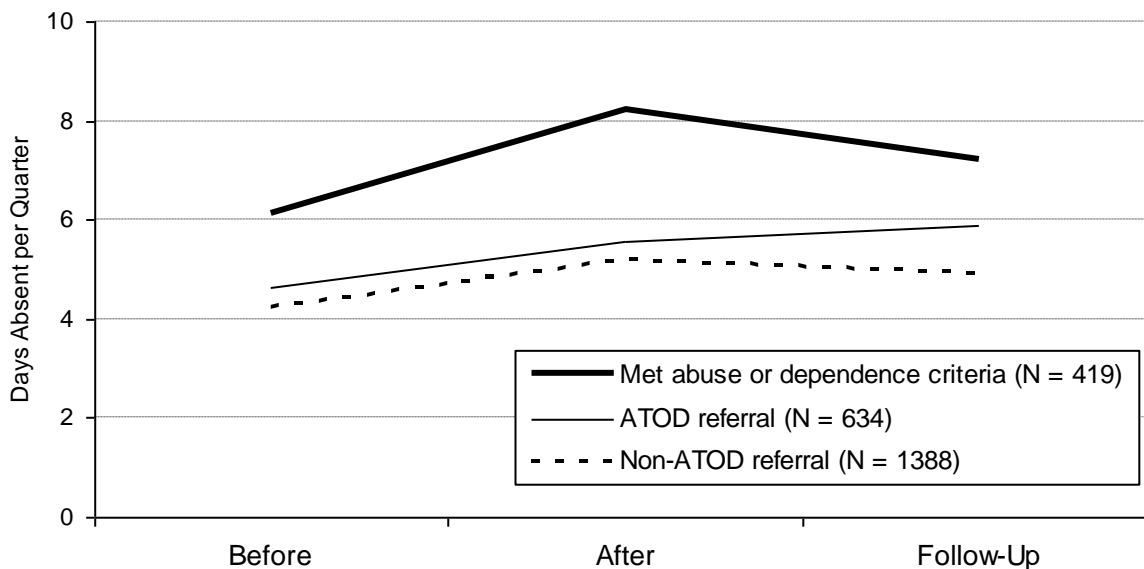
Figure 16 shows the change in GPA over three spring grading periods for students referred to the program. Each line plots the average GPA for a group defined by severity of substance use at intake. Little change in GPA following participation in the program was observed. A longer time frame may be needed to observe improvements, but at the least there is no evidence of a strong decline in performance for those referred to the program.



**Figure 16.** Longitudinal trends in GPA by severity of substance use and level of participation. Students first served by the program during the 2005–06, 2006–07, or 2007–08 school years showed little change in GPA by the end of the following school year. (ATOD=alcohol, tobacco, and other drug).

Students who met criteria for substance abuse or dependence, however, did not perform as well as others. This finding could be construed as support for early identification of substance users—before they begin to experience the consequences of abuse or dependence. It also reflects the fact that poor school performance is a risk factor predicting a greater propensity for substance dependence.

The evaluation team conducted a similar analysis using attendance data. Figure 17 shows the longitudinal trends in days absent per quarter. School records showed slight increases in days absent initially. However, the second year follow-up with students who met substance abuse or dependence criteria suggested no further increase in days absent.



**Figure 17.** Longitudinal trends in attendance by severity of substance use and level of participation. School records suggest no significant change in attendance a year after first participating in the program during the 2005–06, 2006–07, or 2007–08 school years. (ATOD=alcohol, tobacco, and other drugs).

The findings for students meeting substance abuse or dependence criteria are consistent with clinical experience suggesting that these adolescents are often identified at a time when their substance abuse is having an increasing impact on their lives, including school performance, and that considerable time may pass before they begin to make healthier decisions as a result of counseling, treatment, or other interventions.

In general, these data fail to demonstrate any short-term improvement in academic performance or attendance for students referred to the SAPISP. It may be that the program intervened before school performance had deteriorated, making it difficult to show change. One can speculate that without the early intervention of the program, many of these students would have demonstrated significantly less school success after two years. However, a longer term study with a comparison group would be needed to test this hypothesis.

Each year local grantees attempt to identify students most at risk of developing a dependence on drugs or alcohol. Over time, the level of use among referred students has declined. An alternative explanation may be that students developing dependence are identified at an earlier stage now. Perhaps it is no longer reasonable to expect an improvement in GPA or attendance.

## Limitations

The results discussed in this section are encouraging, but certain limitations of the data should be considered. First, most of these results are based on student self-report. However, past research has shown that when confidentiality is assured and the purpose of the survey is clear, most students take surveys seriously and are remarkably honest in reporting behavior that is socially undesirable or illegal (Deck, Einspruch, and Nickel, 2001; National Institute on Drug Abuse, 1992). The administration guidelines for the program evaluation survey were patterned after those developed for the Healthy Youth Survey to ensure valid responses.

Second, some students who met guidelines for administration did not complete the Program Evaluation Form at both points in time. Examples of other reasons given for students entering the program after that time were: the student was in crisis and could not be pretested; it was not possible to obtain release time for the student to complete the pretest or posttest; and the student left the school before the posttest could be administered. In general, the results appear to be representative of all the secondary students served with the caveat that certain groups are underrepresented each year. These groups included females; students in Grades 9–12; students with a high severity of drug use; students served individually rather than in group settings; students with low participation; and students who exited the program by moving, dropping out, or suspension.

A third limitation of the data relates to the short timeframe for data collection (from program intake to program exit or the end of the school year). A follow-up study of student outcomes at least one year after program participation would be a useful complement to this study.

Despite these limitations, the results presented in this report provide strong evidence that the program has been effective. The research literature offers a modest number of careful evaluations of well-implemented prevention and intervention programs that provide clues about the order of magnitude of changes in substance use that can be expected of such programs under the best conditions. Although none of these studies is directly comparable to this evaluation, they have led the evaluation team to conclude that the reductions in substance use reported here are respectable (e.g., Botvin, 1996; Hansen, Johnson, Flay, Graham, and Sobel, 1988; Pentz, 1994).

## Conclusions

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Overall, the results of this evaluation reflect favorably on the effectiveness of the SAPISP. Local projects have implemented student assistance programs that serve about 800 schools annually. Between 16,000 and 20,000 students benefit annually from indicated or selective prevention activities supported by program funds. The outcome assessment provides strong evidence that the program is having the desired impact on students' lives. Students have reported stronger social skills and a greater commitment to school and a high level of satisfaction with program services. After participating in the program, fewer students report antisocial behavior or substance use.

Despite these positive results, there is always room for improvement and refinement in the implementation of the program across Washington. Although the general student assistance model has been in place for some time, local programs have been trying to standardize practices based on a recent statewide program manual.

Perhaps the greatest challenge will be to preserve the level of service and the outcomes achieved in the face of anticipated reductions in funding. A severe recession is currently hammering the economy, and this program is beginning to feel the adverse effects. A small emergency cut in local grants was implemented near the end of 2008–09 and an additional cut in funding was implemented for 2009–10. Further cuts are likely for 2010–11. Clearly, some difficult planning will be needed to weigh the various objectives of the SAPISP to determine what to cut and what to preserve.



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