

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

2010–11 Annual Report



Randy I. Dorn
State Superintendent of
Public Instruction

January 2012

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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 mix of local, state, and federal (e.g., Safe and Drug-Free Schools and Communities) funds, places intervention specialists in schools to implement comprehensive student assistance programs that address problems associated with substance use and violence. As stated in the act (Engrossed Second Substitute House Bill (ESSHB) 1793, Subpart B, Section 310, Paragraph 2), intervention specialists 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?

Program funds, nearly \$4 million in 2010–11, are distributed to the nine Educational Service Districts (ESDs) that serve school districts across the state. Funding allocations are based on a formula that accounts for both the student enrollment and the estimated need for services in 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 alcohol, tobacco, or other drugs, or; (d) developing a dependence on alcohol or other drugs. An array of counseling, peer support groups, social skills training, and individual and family interventions are employed 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-based services such as substance abuse treatment. In 2010–11 intervention services were provided to 11,508 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 SAPISP has resulted in positive outcomes in each of these areas as measured by a self-report instrument administered to students before and after participation in program services.

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

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

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

- Significantly more students perceived moderate to high risk in five 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, 35 percent fewer students reported marijuana use, 28 percent fewer students reported binge drinking (5 or more drinks at one time), and 12 percent fewer students reported cigarette use in the past 30 days after participating in program services.

School success. Teacher ratings provided some evidence that participation in SAPISP can be linked to improved school success:

- Elementary and alternative school teachers observed improved classroom performance in 62 percent of the students with unsatisfactory performance at baseline. Nearly 30 percent of students with satisfactory classroom performance at baseline also showed improved performance after participating in the program.

How can I learn more about this program?

To learn more about SAPISP, contact Dixie Grunenfelder at OSPI 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 State Healthy Youth Survey 2010: Analytic Report* (Washington State Department of Health et al., 2011).

Introduction

Substance use continues to be a significant problem among young people. Recent survey data indicate the prevalence of substance use among students in Washington State. Of those Grade 12 students who participated in the 2010 Washington State Healthy Youth Survey (Washington State Department of Health et al., 2011), at some time in their lives, 71 percent had tried alcohol, 41 percent had tried cigarettes, 46 percent had tried marijuana, 11 percent had tried inhalants, and 9 percent had tried cocaine. Of even greater concern, 40 percent of those high school seniors reported having used alcohol in the past 30 days, 20 percent reported having smoked cigarettes in the past 30 days, and 26 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 2010 results are consistent with the 2008 Healthy Youth Survey results (Washington State Department of Health et al., 2010). These findings underscore the enduring 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 SAPISP. OSPI allocates funds to local grantees for the purpose of placing alcohol and other drug intervention specialists in schools. The program focuses on schools with the highest concentrations of at-risk students and the provision of services to students in Grades 5 through 12.

Section 311 of ESSHB 1793 indicates that the intervention specialist 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.” SAPISP intends for intervention specialists to:

- Provide early alcohol and other drug prevention and intervention services to students and their families.
- Assist in referrals to 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 prevention and intervention services in schools will enhance the classroom environment for students and teachers and better enable students to realize their academic and personal potentials.” (ESSHB 1793, Section 310)

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 (Wickizer [2007] estimated that the total economic cost of alcohol and drug abuse in Washington

State in 2005 was \$5.21 billion or \$832 for every noninstitutionalized person). That this concern is a priority to the state is evident in the report *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State* (Behavioral Health and Recovery, 2007), which presented data on the state's progress toward the Healthy People 2010 objectives for youth. Although significant progress had been made at the time of the report, Washington was falling short of the national goals for adolescent use of alcohol, tobacco, marijuana, and other illicit drugs.

SAPISP also relates to Washington State's Essential Academic Learning Requirements (EALRs) for health and fitness. *Washington State K–12 Health and Fitness Learning Standards* (Washington State OSPI, 2008) states that the EALRs for health and fitness are based on the idea that:

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. . . 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. (p. 1)

Previous Evaluations

OSPI sponsors ongoing statewide evaluation of SAPISP. RMC Research Corporation prepares annual summaries of student-level service and outcome data (see Deck [2011] for the 2009–10 annual report).

Methodology

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

Documentation of program services. RMC Research maintains a Web based reporting system for SAPISP activities and outcomes. Intervention specialists enter information that: (a) describes universal prevention activities offered to all students; (b) describes selective and indicated prevention services provided to referred students, and; (c) assesses program outcomes for participating students. Grant coordinators and intervention specialists can use the Web based system to run interactive reports summarizing participant characteristics, service participation, and program outcomes.

Student outcomes. Students referred for selective and 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 classes passed and failed. RMC Research conducted a longitudinal study that tracked grade and attendance data over three years for a random sample of approximately 20 percent of the students participating in SAPISP during the 2007–08, 2008–09, and 2009–10 school years. In 2010 a significant change pertaining to the collection of follow-up data was implemented. OSPI elected, with support from Washington’s Division of Behavioral Health and Recovery (DBHR), to discontinue the aforementioned approach in favor of collecting longitudinal data on the number of classes passed and the number of classes failed for all students receiving at least three contacts with an intervention specialist. Baseline data is collected for the first academic term of the current school year and follow-up data is collected for the first academic term of the subsequent school year. This approach is less burdensome for intervention specialists and serves as a broader and more meaningful measure of SAPISP impacts on student performance. OSPI’s investment in collecting follow-up data on all program participants reflects a commitment to connect substance use prevention and intervention services to schools’ core function of promoting academic achievement.

The first implementation of this change involved students served during the 2010–11 school year. For these students intervention specialists reported baseline data from fall 2010 and are currently collecting follow-up data from fall 2011. The follow-up data for 2010–11 were not available for this report but will be included in the 2011–12 annual report.

Program Logic Model

Comprehensive school-based substance abuse prevention programs must provide both schoolwide activities and specialized services to students identified with specific needs. As noted by Robertson, David, and Rao (2003, p. 18), prevention programs can be described by the audience or intervention level for which they are designed:

- Universal programs are designed for the general population, such as all students in a school.
- Selective programs target groups at risk or subsets of the general population such as children of drug abusers or poor school achievers.
- Indicated programs are designed for people who are already experimenting with drugs.

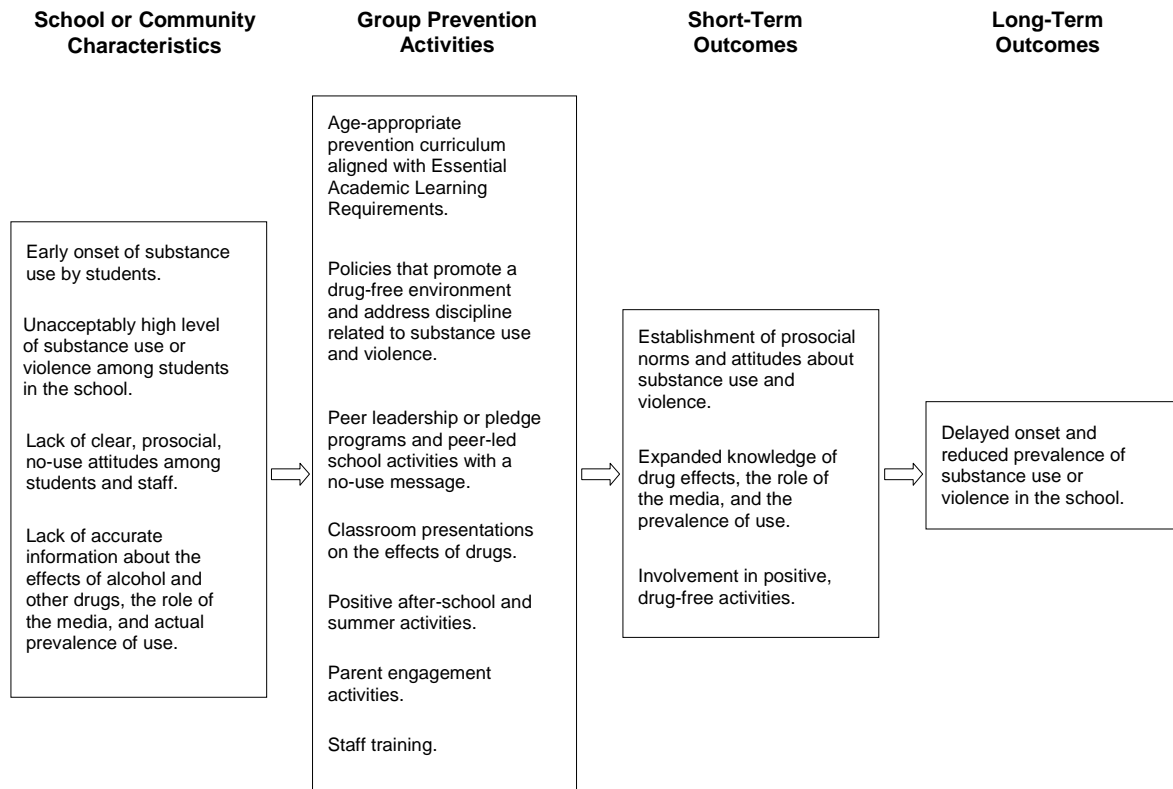
SAPISP provides a continuum of student support services covering the full range of prevention strategies, including referral to treatment services. Appropriate prevention strategies include:

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

Exhibit 1 illustrates the general logic of universal prevention services provided by intervention specialists, linking school characteristics, program activities, and the intended short- and long-term outcomes. A schoolwide needs assessment may reveal the existence of undesirable student attitudes or behaviors, suggesting 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 alcohol and other 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 SAPISP provides prevention services to achieve particular prevention-related outcomes.

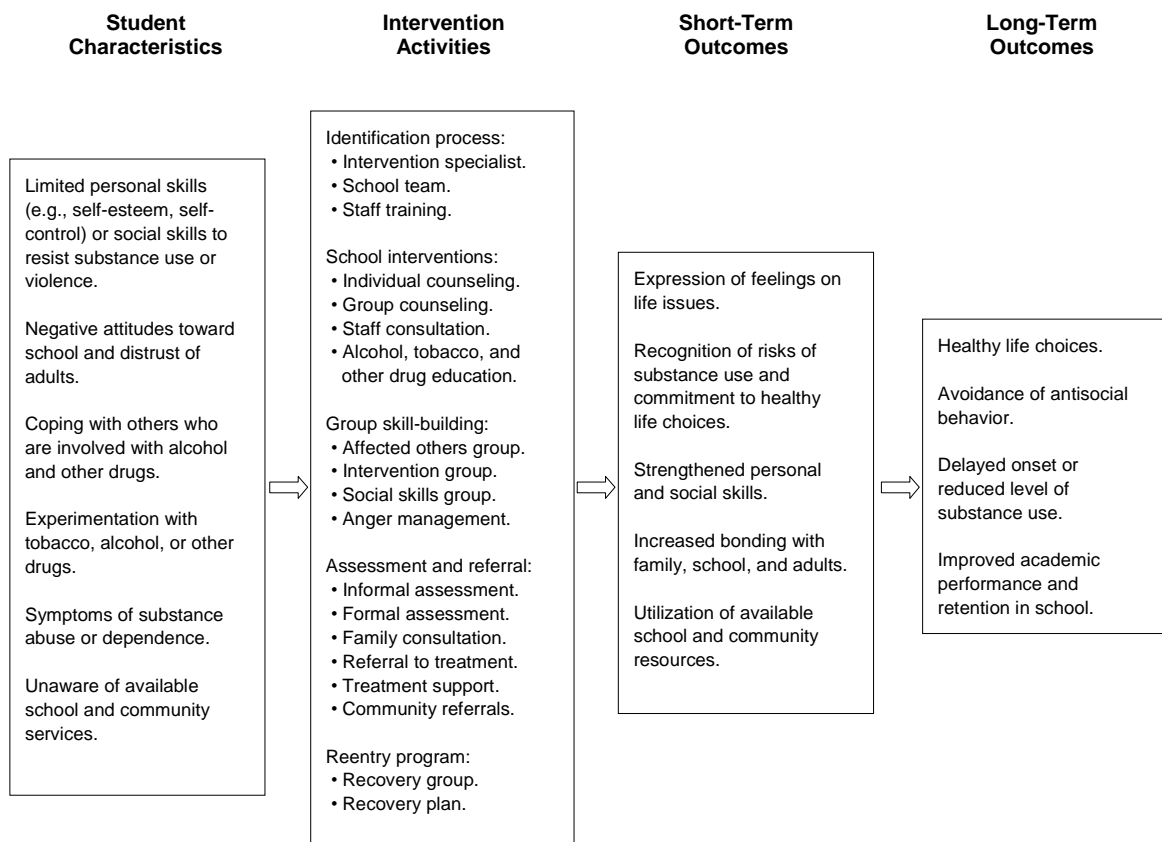
Exhibit 1 Universal Prevention Services Logic Model



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

Exhibit 2 illustrates the logic of the selective and indicated prevention services provided by intervention specialists. Diverse student characteristics prompt intervention specialists to implement comprehensive school-based interventions and to refer students to other school and community-based 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 SAPISP provides intervention services to achieve particular intervention-related outcomes.

Exhibit 2 Selective and Indicated Prevention Services Logic Model



Casey—Prevention Through Healthy Choices

Casey is a friendly, ambitious adolescent striving to develop leadership qualities and success in life. She considers herself a “really neat person” and wants to show people that she is not like her parents. Her father is in prison and her mother is an alcoholic and drug addict that abandoned her and her sister when she was 12 years old.

When Casey was referred to the intervention specialist, she already had a history of drug use and was contemplating suicide. Casey began receiving counseling and participating in a weekly support group that helps students develop communication and problem-solving skills. Casey gained a greater sense of self-awareness and learned to express her feelings. As Casey’s confidence and self-esteem grew, she developed a more positive attitude about life. Her grades improved and she ran for class vice president. She began participating in school sports and helped start a Students Against Drunk Driving club.

Participating in the support group helped Casey understand that her family situation is not her fault.

She sees the intervention specialist and school counselor as mother figures and cherishes their love and support. She reports that they help her make healthy choices and cope with everyday life. Casey knows that she cannot change the past, but considers herself a better person for what she has been through. She says, “My past was bad but my future won’t be.”

Program Description

This section describes SAPISP in relation to five evaluation questions:

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

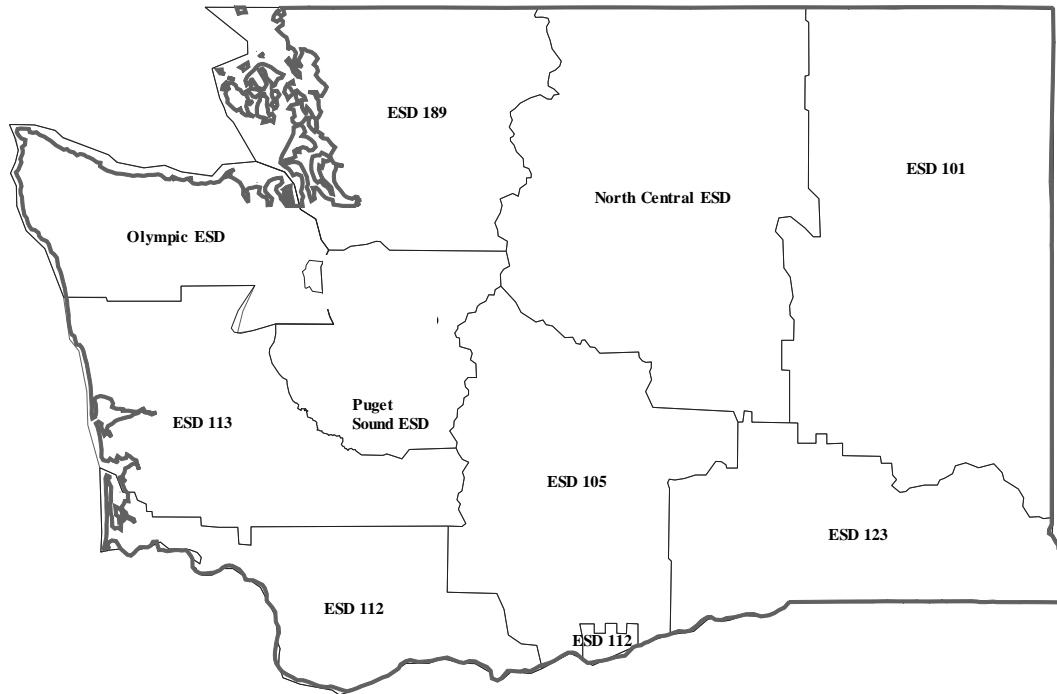
Who are the Local Grantees?

Finding: Nine grantees implemented SAPISP in the 2010–11 school year. The local programs served all geographic regions of the state.

Local grantees. Nine local programs provided SAPISP services to students across the state (see Exhibit 3). The grantees include the state’s nine ESDs:

- 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 and Aberdeen, Chehalis, Elma, Hoquiam, North Beach, Olympia, Raymond, Tenino, White Pass, and Winlock School Districts).
- 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 Districts is the fiscal agent).

Exhibit 3 Map of Educational Service Districts



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. SAPISP now serves all geographic areas of the state and distributes grant funds more equitably. The grant coordinators and OSPI staff meet to plan the overall direction for the program, develop strategies for coordinating the various funding streams, and share information about effective practices.

Finding: *Program funding had remained flat between 1990 and 2009, which allowed inflation to erode 40 percent of the buying power of grant funds. A nearly \$1.5 million reduction in funding in 2010 greatly reduced the level of services provided across the state.*

Program funding. Since its inception SAPISP has operated with a biennial budget of about \$9 million plus in-kind matching funds (Deck and D'Ambrosio, 2000). This budget represents approximately 50 percent of the federal Performance Partnership Grant from the Center for Substance Abuse Prevention administered by the Division of Behavioral Health and Recovery in Washington's Department of Social and Health Services. The

allocated funds remained relatively constant between 1990 and 2009, but with no provision for inflation. Averaged over the 2009–10 school year, a dollar was worth about \$0.60 in 1990 dollars when adjusted using the Consumer Price Index published by the United States Bureau of Labor Statistics (<ftp://ftp.bls.gov/pub/special.requests/cpi/cpiiai.txt>). Consequently, the buying power of the program’s funding decreased about 40 percent. In the 2010–11 school year, however, SAPISP experienced a real dollar reduction in funding due to the loss of federal Safe and Drug-Free Schools and Communities funds. Funding for SAPISP for the 2010–11 school year was \$3.8 million, an approximate \$1.5 million reduction in funding compared to the 2009–10 school year (see Exhibit 4).

The vast majority of program funds are invested in program staff—particularly the intervention specialists 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 \$330 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 publicly funded services.

Matching funds. Other funding streams contribute to local prevention efforts and should be considered part of the match. Prior to the 2010–11 school year, school districts received an allocation of federal Safe and Drug-Free Schools and Communities funds and the state Department of Health contracted with ESDs to implement school-based tobacco prevention strategies. In 2010–11 only a small amount of Safe and Drug-Free Schools and Communities carryover funds and a 50 percent reduction in Department of Health tobacco funds remained to support SAPISP. Local programs did, however, access matching funds from sources such as grants from the Centers for Disease Control and Prevention, the Center for Substance Abuse Prevention, the United States Department of Education, and other agencies to expand or maintain services or adapt special programs. Many rural grantees coordinate multiple funding streams, including local school dollars, to place intervention specialists in schools full or part time.

Finding: *In 2010–11, 195 intervention specialists in nine local programs provided direct services to more than 300 schools statewide.*

Intervention specialists. Trained primarily as chemical dependency professionals or certified prevention specialists, intervention specialists 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 SAPISP, many are funded full time. As of June 2011 local programs had 195 intervention specialists placed in schools.

Penetration of services. Historically, 600 to 800 schools across Washington State have received SAPISP services annually. Due to a reduction in funding, SAPISP was only able to reach approximately 300 schools in 2010–11. Consistent with the intent of

the program, secondary schools are the most likely to receive services 105 middle schools, 160 high schools, and 26 alternative schools received services in 2010–11. In contrast, less than ten elementary schools received program services. Overall, SAPISP served about 1 out of every 7 public schools in Washington.

Finding: *Traditionally, intervention specialists have provided direct services to more than 17,000 students annually despite eroding resources. Steep resource declines in 2010–11 reduced the number of students served to fewer than 12,000.*

Number of students served. Exhibit 4 details the level of funding, the number of participating schools, the number and full-time equivalent (FTE) of intervention specialists, and the number of students who received direct services for each year of SAPISP. Despite the decline in intervention specialist FTE directly supported by the grant, the number of students served remained relatively stable through the 2009–10 school year due to the contribution of in-kind funds. By the 2010–11 school year, however, reductions in grant funding began to have an impact on intervention specialist FTE supporting SAPISP and the number of students receiving direct services.

Exhibit 4
Program Expenditures, Staffing, and Service Delivery 1989–2011

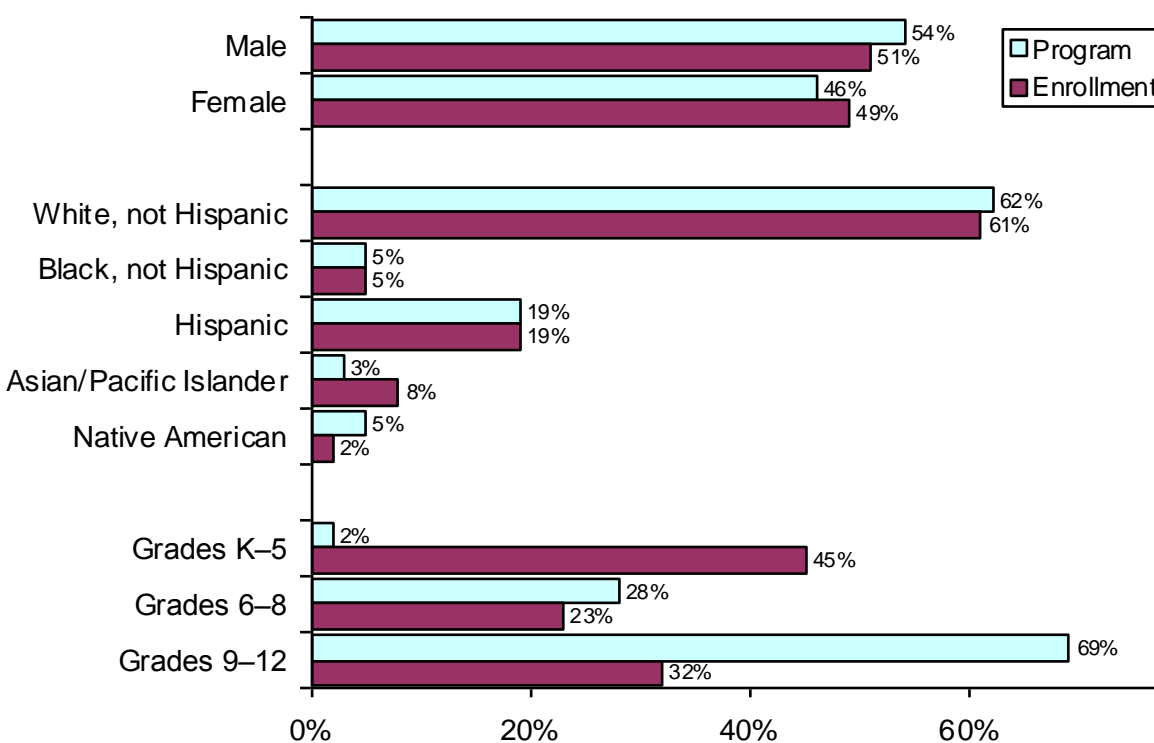
Year	Grant Award (Thousands)	Grant Adjusted for Inflation ^a	Schools Served	Intervention Specialists		Students Served
				FTE	No.	
1989–90	\$4,808	\$4,808	601	147	198	11,236
1990–91	\$4,808	\$4,614	706	140	206	21,209
1991–92	\$4,808	\$4,479	683	140	241	21,198
1992–93	\$4,808	\$4,349	507	130	245	19,865
1993–94	\$4,808	\$4,241	713	131	214	18,804
1994–95	\$4,808	\$4,124	691	121	205	19,361
1995–96	\$4,808	\$4,005	607	121	204	17,649
1996–97	\$4,808	\$3,916	612	120	206	18,807
1997–98	\$4,808	\$3,856	555	115	222	19,607
1998–99	\$4,808	\$3,772	618	102	242	21,275
1999–2000	\$4,808	\$3,650	704	115	268	21,099
2000–01	\$4,808	\$3,549	765	125	292	22,947
2001–02	\$4,808	\$3,493	684	108	305	23,049
2002–03	\$4,808	\$3,416	762	145	333	22,185
2003–04	\$4,928	\$3,410	782	104	294	18,857
2004–05	\$4,928	\$3,298	809	105	278	16,056
2005–06	\$4,928	\$3,195	699		277	18,446
2006–07	\$4,928	\$3,154	538	172 ^b	253	18,358
2007–08	\$4,928	\$3,043	636	198 ^b	257	16,886
2008–09	\$5,252	\$3,043	607	197 ^b	259	18,183
2009–10	\$5,481	\$3,274	552	174 ^b	238	17,100
2010–11	\$3,833	\$2,208	313	128 ^b	195	11,508

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.
^a1989–90 dollars. ^bFTE is now based on the total from all sources.

Which Students do Local Programs Serve?

Characteristics of the students served. Consistent with the intent of SAPISP, the majority of the students served in 2010–11 were enrolled in secondary schools (see Exhibit 5). Overall, 69 percent of the students served were in Grades 9–12 and 28 percent were in Grades 6–8. Overtime, the proportion of elementary school students (below Grade 6) served has declined to 2 percent. In 2010–11 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. Despite the fact that 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.

Exhibit 5
Characteristics of the Students Served in 2010–11



Note. $n = 11,508$.

Students referred to the program are often involved in alcohol and other drug use. In 2010–11, 67 percent were referred for substance-related issues. The goal of 74 percent of the referrals was to increase students' perceptions of the risks of substance use. Referrals also aimed to strengthen protective factors such as decision-making (61

percent) and refusal skills (58 percent). Intervention goals for substance use centered on marijuana (51 percent), alcohol (40 percent), and tobacco (30 percent).

What Services are Provided to Students?

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

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 substance use is a multifaceted endeavor that includes a kindergarten through Grade 12 prevention curriculum, district and school 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, 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 individual counseling, parent conferences, behavior contracts, and peer support groups.
- **Referral.** Students are referred to in-school programs or community-based assessment, treatment, or other 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 2010–11 school year, 11,508 students in Washington State received direct services from SAPISP intervention specialists. Although a large number of students were served in peer support group or class settings (63 percent), the majority of the students received individual counseling (68 percent). Intervention specialists 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 recovery support to maintain sobriety. Local programs typically implement one or more of three common types of peer support groups and four common types of other groups or classes:

- **Affected others groups** help students learn to cope with the impact of another person's use (1,594 students were referred to affected others groups in 2010–11).
- **Intervention groups** challenge students who have begun to use alcohol or other drugs to consider their reasons for use and to quit using (3,112 students were referred to intervention groups in 2010–11).
- **Recovery assistance groups** assist students in the recovery process to make the transition back to school after treatment and to develop relapse prevention skills (813 students were referred to recovery assistance groups in 2010–11).
- **Pledge or leadership clubs** help reinforce the no-use decision of students who have not yet begun to experiment with alcohol and other drugs (227 students were referred to pledge or leadership clubs in 2010–11).
- **Alcohol, tobacco, and other drug education classes** teach students at risk of beginning substance use about the consequences and effects of using alcohol, tobacco, and other drugs (1,617 students were referred to alcohol, tobacco, and other drug education classes and 821 students were referred to tobacco-specific education or cessation classes in 2010–11).
- **Violence prevention classes** help students manage their anger and resolve conflicts without violence (117 students were referred to violence prevention classes in 2010–11).
- **Social skills classes** help students develop the social skills necessary to resist pressure to use alcohol or other drugs and to improve interactions with peers (571 students were referred to social skills groups in 2010–11).

In addition to providing support group services, intervention specialists provide violence prevention programming, conduct substance abuse 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 universal prevention activities conducted by intervention specialists target the whole school or all students at specific grade levels. Exhibit 6 summarizes the universal prevention activities provided to students by the nine grantees during 2010–11. The prevention framework promoted by the Center for Substance Abuse Prevention serves as the basis for the organization of the information. For each service type, Exhibit 6 shows the number of activities and sessions conducted, the total number of participants, and the average hours per session participants attended.

Exhibit 6
Universal Prevention Activities Provided to Students
in 2010–11 by Service Type

Activity Type	Number of Activities	Number of Sessions	Total Participants	Average Hours per Session
Awareness				
Information dissemination to students	837	837	319,253	1.27
Classroom presentations about services	812	812	36,875	0.86
Classroom presentation on ATOD ^a issues	785	785	31,980	1.31
ATOD awareness event	510	510	215,634	2.38
Community service activities	51	51	7,335	2.18
Curriculum				
Life Skills	164	545	9,479	1.34
Other recognized prevention curriculum	129	539	6,200	1.03
Local prevention curriculum	125	345	5,320	1.38
TATU ^b peer education	97	239	5,534	1.52
TATU leader training	85	155	1,046	1.79
Second Step	70	182	2,358	1.20
END: Ending Nicotine Dependence	11	33	26	0.83
Natural Helpers leader training	6	6	477	1.97
Project Alert	5	29	645	1.97
Great Body Shop	3	3	235	1.00
NOT: No On Tobacco	3	3	3	0.83
Project TNT: Towards No Tobacco Use	2	20	12	0.90
TRIBES	1	3	5	0.50
Education				
Prevention education groups	395	1,092	9,687	1.04
Classroom series on ATOD issues	55	158	7,707	2.28
Peer				
Prevention clubs	800	1,916	27,234	1.06
Peer leadership programs	74	255	6,703	1.28
Peer mentoring programs	47	138	3,147	1.65
Community prevention coalitions	19	21	442	2.40
Peer mediation programs	9	30	131	1.61
Planning				
Team prevention planning	251	251	2,391	1.12

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.

^aATOD = Alcohol, Tobacco, or Other Drugs. ^bTATU = Teens Against Tobacco 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, and 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 2010–11 most local grant coordinators reported activities in the awareness and peer domains as the core of their overall universal prevention strategy. Substantial effort was also expended on curriculum and educational activities. Pressure to implement proven, science-based prevention curricula has increased in recent years, and Exhibit 6 specifies the names of the curricula implemented. During 2010–11 students participated in 2,102 sessions that utilized science-based prevention curricula recognized by federal agencies.

Intervention specialists also conduct universal prevention activities targeting families, school staff, and the general community. These strategies often focus on increasing awareness of the issues and needs of students and encompass planning, education, and curriculum. Exhibit 7 summarizes the universal prevention activities provided in 2010–11. Awareness and planning activities accounted for the largest number of activities and participants. Curriculum and education activities occurred with less frequency but tended to be more time intensive for participants.

Exhibit 7
Universal Prevention Activities Provided to Families, School Staff,
and the General Community in 2010–11 by Service Type

Activity Type	Target Audience	Number of Activities	Number of Sessions	Total Participants	Average Hours per Session
Awareness					
Information dissemination	Staff	764	764	38,089	0.84
Information dissemination to parents	Family	477	477	219,543	1.32
Awareness presentation	Staff	165	165	5,133	1.00
Information dissemination	Community	163	163	54,157	1.81
Awareness event	Community	154	154	33,047	3.05
Awareness presentation to parents	Family	106	106	21,719	2.00
Awareness presentation	Community	75	75	3,971	2.53
Prevention event	Family	35	35	7,970	2.13
Curriculum					
Professional development on curriculum	Staff	36	40	908	1.73
Strengthening families	Family	21	27	624	3.12
Education					
Professional development on ATOD ^a issues	Staff	36	40	3,288	1.30
Parent education series	Family	13	27	1,375	1.46
Planning					
Technical assistance/consultation	Staff	1,171	1,171	7,953	1.23
Assessment and referral services	Staff	532	1,505	6,113	1.04
Advisory board/coalition meeting	Community	222	556	3,467	1.63
Collaborative needs assessment	Community	154	154	2,367	1.57
Policy/procedure development and implementation	Staff	156	257	1,420	1.38

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.

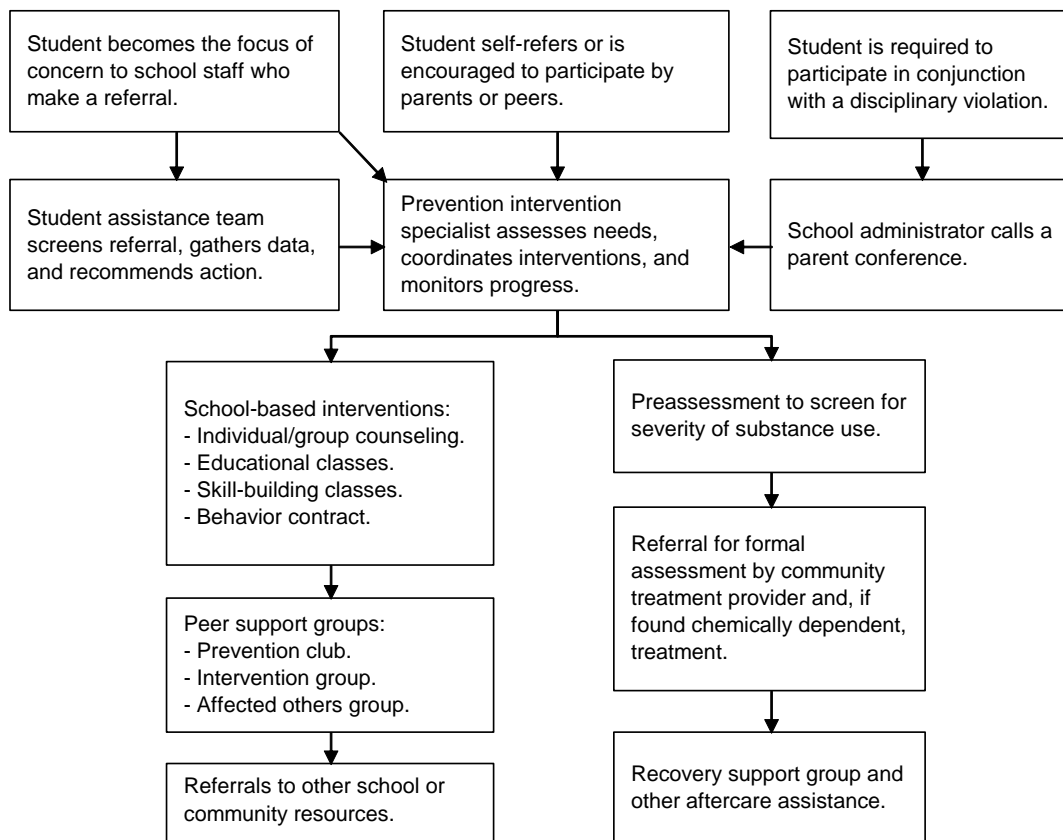
^aATOD = Alcohol, Tobacco, or Other Drugs.

How are Students Identified for Services?

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

Referral process. Students are often referred by school staff who become aware that they may be in need of help. Staff referrals include those made by school administrators as part of a disciplinary action (approximately a third of all referrals). Intervention specialists 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 intervention specialists. Pursuant to a referral, information from a variety of sources is collected and a substance abuse 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. Exhibit 8 illustrates this process.

Exhibit 8
Typical Student Assistance Program Referral Process



Intervention specialists often indicate multiple presenting issues for students referred to SAPISP and typically have a wide array of case management services at their disposal to provide directly to students or as referrals to other school- or community-based service providers according to the type and severity of need. Exhibit 9 summarizes the 2010–11 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, medical and financial assistance services, Child Protective Services, living arrangements and housing services, and transportation services.

Exhibit 9
Case Management Referrals in 2010–11

Case Management Service	Referral Rate
Alcohol and other drug assessment	40%
Mental health care	27%
School counselor/psychologist	24%
Alcohol and other drug outpatient treatment	20%
Community support groups	12%
Alcohol and other drug counseling	11%
Other school/community referrals	8%
Physical health care	6%
Alcohol and other drug inpatient treatment	5%
Police/juvenile justice	5%
Family worker	3%
Medical/financial assistance	3%
Child Protective Services	3%
Living arrangements	2%
Transportation	2%
Employment/vocation	1%
Child care	< 1%

The SAPISP logic model provides a conceptual framework for relating intervention goals to intended outcomes. Using the model as a guide, grantees identify the risk and protective factors targeted for change outcomes using the framework proposed by Hawkins, Catalano, and Miller (1992). To show the relative weight intervention specialists gave to these factors in 2010–11, Exhibit 10 lists each risk or protective factor and the percentage of students with intervention goals related to the risk or protective factor during the service period.

Exhibit 10 Intervention Goals in 2010–11

Factor	Students With Factor as Intervention Goal
Strengthen Skills and Attitudes	
Perceived risk of substance use	74%
Decision-making	61%
Refusal skills	58%
Awareness of social influences	56%
School bonding	47%
Communication skills	35%
Assertiveness	22%
Social skills	20%
Self-control	16%
Self-esteem	13%
Family bonding	13%
Social bonding	8%
Reduce or Eliminate Problem Behavior	
Marijuana use	51%
Alcohol use	40%
Tobacco use	30%
Associate with inappropriate peers	22%
Anxiety, depression	14%
Other drug use	14%
Anger/uncontrolled behavior	9%
Truancy	9%
Aggressive behavior	5%

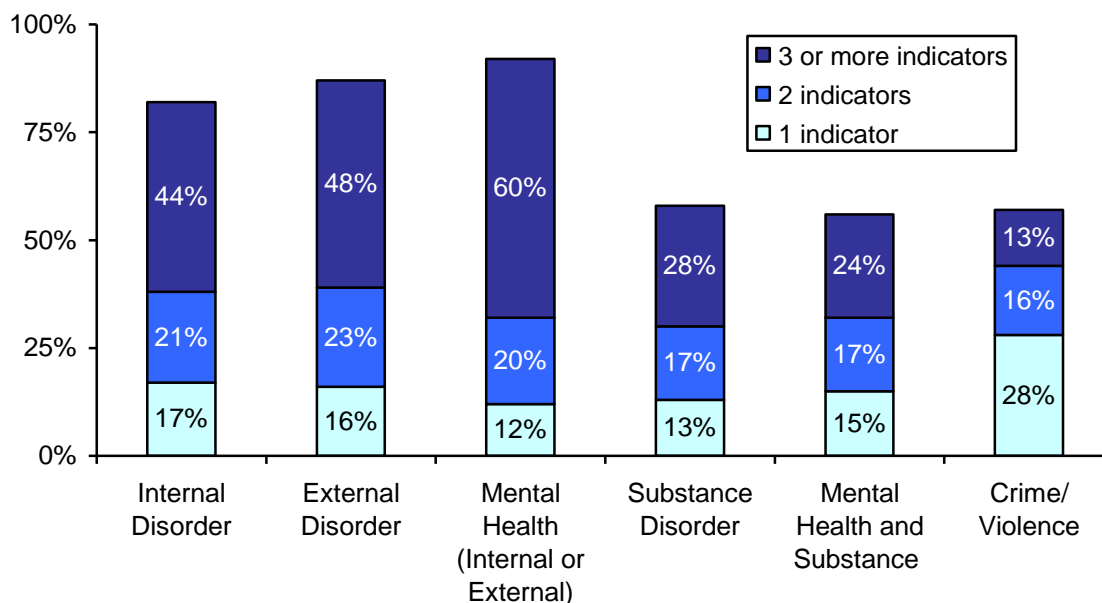
In terms of protective factors, 74 percent of the referred students had strengthening the perceived risk of substance use as an intervention goal. More than half had improving decision-making (61 percent), refusal skills (58 percent), and awareness of social influences (56 percent) as intervention goals. In terms of risk factors, the reduction or elimination of marijuana use, alcohol use, and tobacco use was an intervention goal for 51 percent, 40 percent, and 30 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, intervention specialists 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; see also 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 four, five-item 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 and indicates that the student would likely benefit from a brief intervention in the school setting. A score of three or more suggests a high probability of a diagnosis and indicates that a formal assessment and intervention are appropriate.

Exhibit 11 shows the results of screening 8,390 students across the state in 2010–11. Of these students, 28 percent met the substance abuse treatment referral criteria set by the Division of Behavioral Health and Recovery. Another 30 percent of the respondents reported one or two substance abuse treatment indicators.

Exhibit 11
Screening Results in 2010–11



Note. *n* = 8,390.

Even more troubling is the fact that 60 percent of the students exhibited three or more internal or external mental health treatment indicators. The results for another 32 percent of the students suggested that a brief intervention, perhaps in the school setting, would be appropriate. Most students 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 Washington 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

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 SAPISP during the 2010–11 school year.

Students who enter the program have a wide range of needs. Intervention specialists 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. Overtime these short-term outcomes may lead to long-term outcomes. For example, participation in a group or class that strengthens personal or social skills may later help a student resist pressure to use alcohol, tobacco, and other drugs. Likewise, a student caught experimenting with alcohol or other drugs who is required to attend a class that raises awareness of the risks of substance use may stop experimenting or at least limit future use.

This SAPISP model focuses attention on four basic evaluation questions. As a result of participating in the program have students:

- 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 pursues multiple lines of evidence to develop a more complete picture than any one data source would support. The primary sources of empirical outcome data for this evaluation include student self-report and observations by classroom teachers. In addition, input from administrators, intervention specialists, teachers, parents, and students provide multiple perspectives.

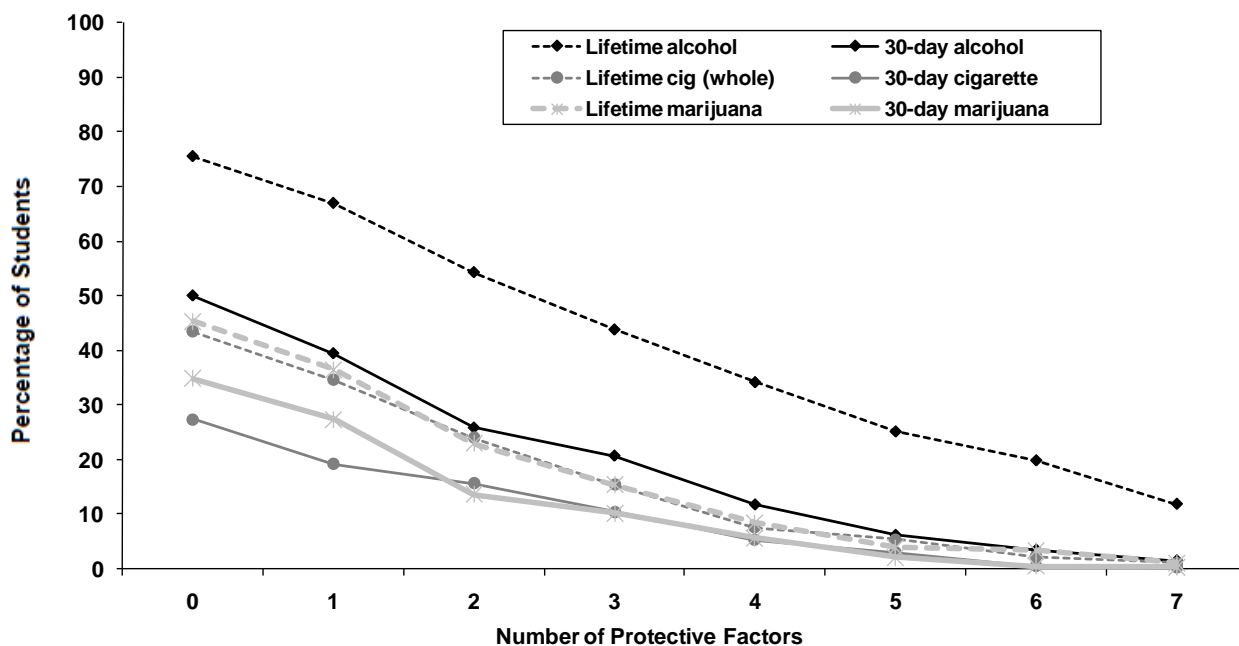
Resiliency and Protective Factors

The prevention literature stresses the importance of various factors in the child, home, school, and community that help young people resist substance 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—whereas 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., Washington State Department of Health et al., 2010) have demonstrated a strong relationship between substance use and various protective factors in the individual, family, and community domains. As Exhibit 12 shows, students who responded positively to many of the protective factor questions on the 2008 Washington State Healthy Youth Survey tended to abstain from substance use, whereas their peers with few protective factors were far more likely to use alcohol or other drugs.

SAPISP is committed to the risk and protective factor model and provides staff training at both the state and local levels. Intervention specialists have generally embraced the concepts of resiliency and protective factors because they can easily relate them to their personal experiences working with adolescents. Of the various services offered, support groups are particularly oriented toward strengthening resiliency and protective factors. More than 60 percent of students referred to SAPISP in 2010–11 were referred to at least one support group or class.

Exhibit 12
Relationship Between Number of Protective Factors and
30-Day Alcohol and Other Drug Use



Note. Source: 2008 Washington State Healthy Youth Survey (Washington State Department of Health et al., 2010).

Assessing Protective Factors

Intervention specialists administer a program evaluation survey to participating students when they exit the program. The survey assesses four basic characteristics of the resilient individual: personal competence, social competence, social bonding, 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 social 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 use 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.

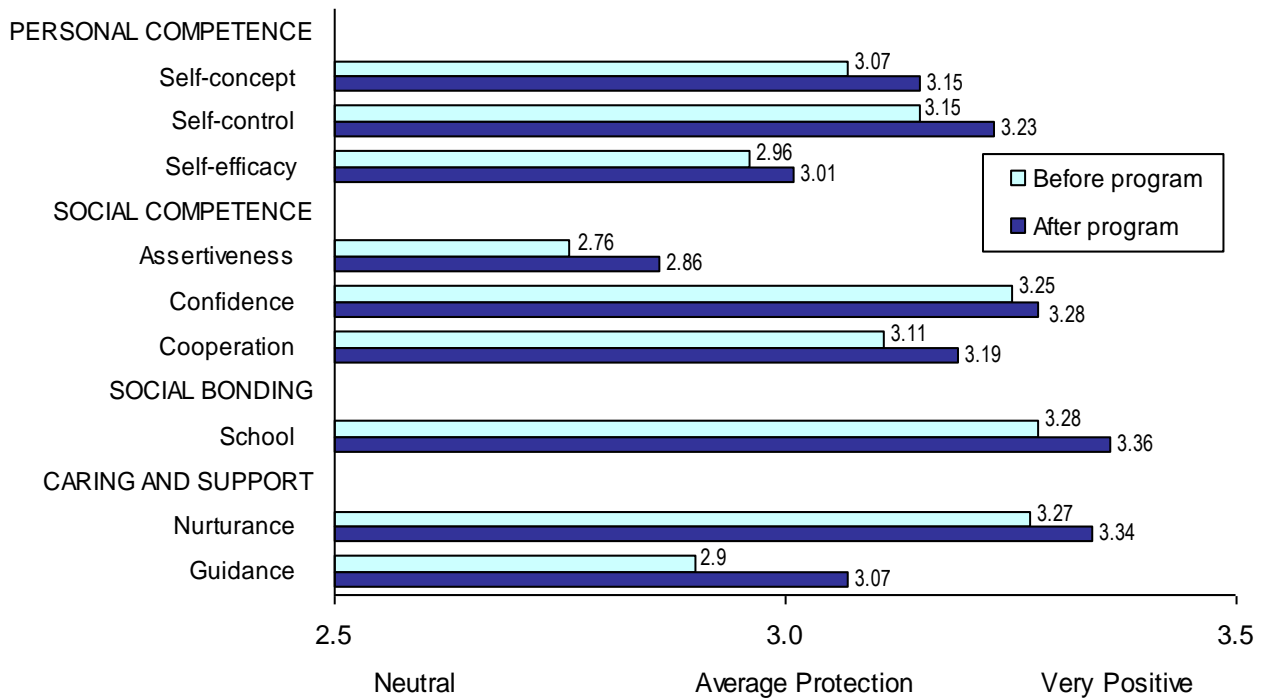
Students are asked to report how they felt before and after participating in the program. Each item is scored on a 4-point scale ranging from *very negative* to *very positive*. The school bonding items utilizes a 5-point scale.

Strengthening Protective Factors

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

Exhibit 13 displays the students' average rating on each protective factor before and after participating in the program in 2010–11. Gains were 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. The 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.

Exhibit 13 Students Reported Greater Protection After Program Participation



Note. n = 5,978.

Students also reported improved bonding with their school after participation in the program. Students have reported that the assistance they received from the intervention specialists helped them reconnect to their school and strengthened their resolve to do well in school. 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. Students have expressed appreciation for the support and guidance provided by intervention specialists. The gains achieved with the protective factors were all statistically significant with the exception of school bonding.

Mandy—Feeling Good About Herself

Mandy is a high school student who is struggling. A concerned teacher referred her to the intervention specialist last year when her grades began to drop and her classroom behavior became extremely disruptive. Mandy hung around known drug users and she admitted to smoking cigarettes and marijuana and being very sexually active. Unable to get along with her mother, Mandy ran away from home regularly. She began participating in individual counseling with the intervention specialist and the school counselor and engaged in outpatient drug treatment. She also participates in a peer support group, and school staff meet with Mandy's mother occasionally. Over time, Mandy has begun to open up and disclose personal matters that needed to be addressed. The relationship between Mandy and her mother has improved significantly. Her grades have improved and she has become involved in school activities. Mandy no longer smokes or uses drugs. Her self-esteem has improved greatly and she has changed her group of friends. She says, "I was made to face my problems. My mom and I now do a lot of things together like shopping or going to concerts. I have learned to stay busy so I stay clean. If I get nervous or need help, I have a support system that I use. I feel good about myself."

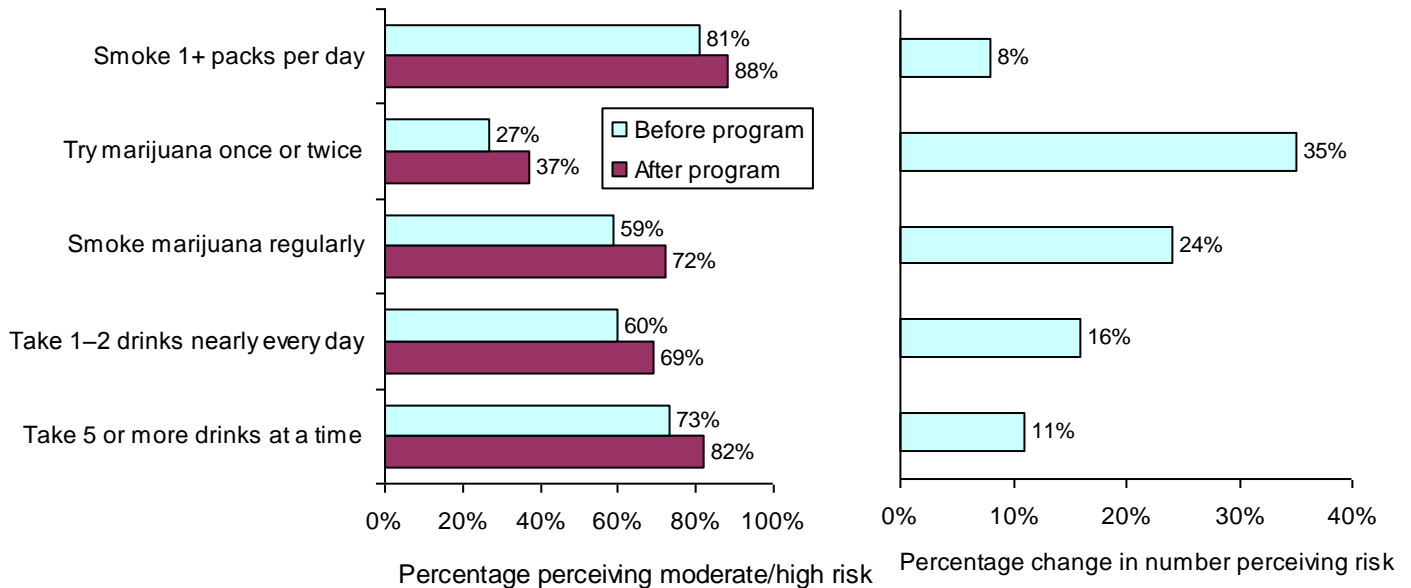
Attitudes About Substance Use

Attitudes about substance use are another important risk factor associated with adolescent substance use. In particular, national and state studies (Johnston, O'Malley, Bachman, and Schulenberg, 2010; Washington State Department of Health et al., 2010) 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).

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

Students who completed the program evaluation survey responded to four questions regarding the perceived risk of specific types of substance use. Exhibit 14 shows the percentage 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 or more drinks at one time)—before and after participation in the program in 2010–11. The exhibit 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.

Exhibit 14 Perceived Risk of Substance Abuse



Note. *n* = 6,108.

Even before participating in the program, most students (81 percent) recognized the risk associated with smoking a pack or more a day, smoking marijuana regularly (59 percent), daily drinking (60 percent), and binge drinking (73 percent). In contrast, relatively few believed that experimenting with marijuana was risky (27 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 to 37 percent—an increase of 10 percentage points, which represents a 35 percent improvement over the baseline. These differences, though modest, are statistically significant.

Rosa—Improved Attitude and Behavior

Rosa is a 14-year-old Hispanic female in middle school. She was referred to the intervention specialist after she was caught smoking at school in Grade 7. Rosa had very low self-esteem—she says she felt like “a piece of garbage.” She regularly used drugs with her friends and did not care about the effects on her body. At home, she often argued with her stepfather. At school, Rosa struggled academically and exhibited violent behavior problems. The intervention specialist provided individual counseling, and Rosa began participating in a peer support group. She now attends school regularly and her grades have improved. She has stopped using drugs and feels more comfortable being herself. Most notably, her attitude and behavior have improved—she received only four office referrals this year, compared to dozens in previous years. Rosa claims that the intervention specialist has helped her completely change her life. She has new friends and is learning to handle her problems without using violence against herself or others. Rosa considers the intervention specialist “a friend, a counselor, and also like a dad.” She says, “The main reason I like talking to [the intervention specialist] is that he tells me the truth. He respects my decisions, but he tells me what he thinks is best. That’s why there should be more people like the intervention specialist to help people like me and make this world a better place.”

Substance Use

Curbing substance use among adolescents is the central purpose of SAPISP. Students engage with the program at various stages of substance use. Some have not yet used alcohol and other drugs but exhibit characteristics or behaviors that put them at risk of starting soon, whereas others are beginning to experiment with cigarettes, alcohol, and marijuana. Still other students have progressed to heavier levels of use and abuse 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.

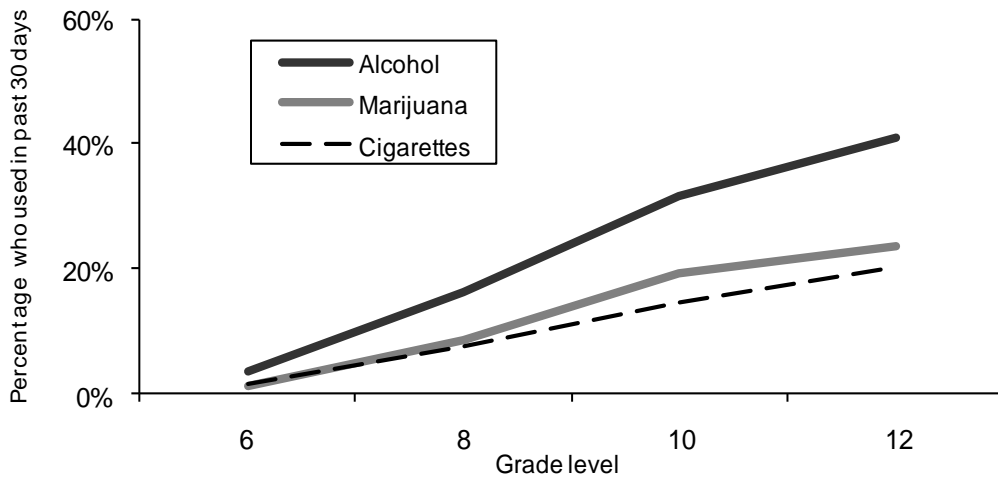
The evaluation team examined several indicators of substance use. Thirty-day use—the percentage of students who reported using a substance at least once during the past 30 days—indicates how many students are currently using a substance, but does not distinguish the level of use. Thirty-day use works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

Past 30 Day Substance Use

Exhibit 15 illustrates the relationship between grade level and substance use observed in the results of a recent survey of adolescent health behaviors in Washington (Washington State Department of Health et al., 2010). 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), they suggest that 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.

Exhibit 15 Statewide Substance Use in Past 30 Days by Grade Level

Note. Source: 2008 Washington State Healthy Youth Survey (Washington State Department of Health et al., 2010).



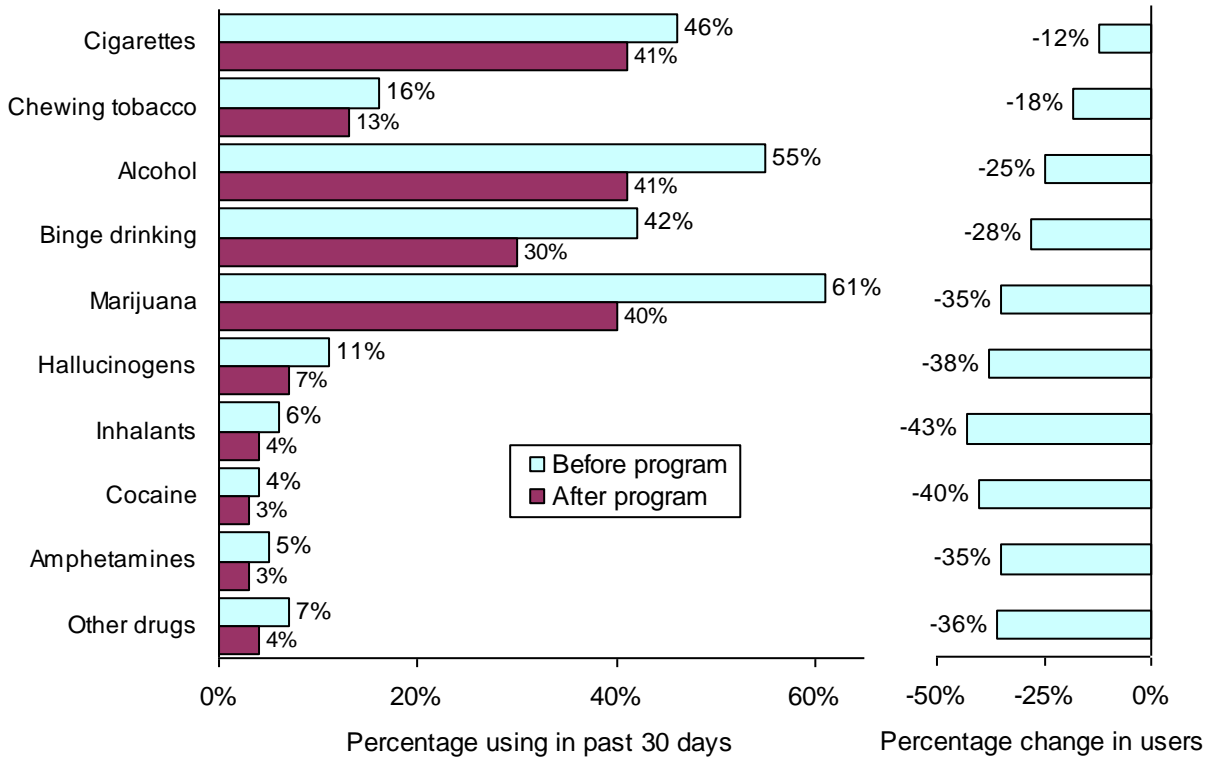
Any Substance Use

The SAPISP program evaluation survey asks students questions about their substance use before and after program participation. The survey administration guidelines direct intervention specialists to ask students in Grades 6–12 with whom they have 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 2010–11, 8,856 students met the survey administration guidelines. Of these, 8,072 students completed a pretest and 6,627 completed both a pretest and posttest.

Finding: *In 2010–11 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 SAPISP.*

A majority (65 percent) of the students referred to SAPISP in 2010–11 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. Exhibit 16 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.

Exhibit 16
Substance Use Among Students With an
Intervention Goal of Reducing Use



Note. n = 4,263.

The results show modest reductions in cigarette use and smokeless tobacco. Even a small decline in tobacco use should be viewed as positive, given the difficulty of quitting. A greater reduction, 25 percent, occurred for alcohol use following participation in the program. Larger reductions were also evident for binge drinking and marijuana use. Whereas 42 percent reported binge drinking in the 30 days before the program, only 30 percent reported binge drinking after the program—a 28 percent reduction in the number of students reporting this particularly risky pattern of alcohol use. Also striking is the 35 percent decline in the number of marijuana users: whereas 61 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, 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 Exhibit 15 suggests, without intervention 30-day use

rates would have reasonably been expected to increase rather than decrease during the school year. Indeed, the rate of substance use among program participants increases by grade level. Exhibit 17 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.

Exhibit 17
Substance Use Among Program Students in Grades 6–8 and Grades 9–12

Substance	Grades 6–8 (n = 1,933)			Grades 9–12 (n = 2,628)		
	Pretest	Posttest	Change	Pretest	Posttest	Change
Cigarettes	39%	33%	-16%	51%	46%	-10%
Smokeless tobacco	11%	9%	-17%	20%	16%	-14%
Alcohol	50%	35%	-29%	59%	45%	-23%
Binge drinking	36%	25%	-30%	45%	33%	-26%
Marijuana	59%	38%	-35%	63%	42%	-34%
Hallucinogens	10%	7%	-32%	12%	7%	-42%
Inhalants	9%	4%	-51%	4%	3%	-30%
Cocaine	3%	2%	-30%	5%	3%	-44%
Amphetamines	4%	3%	-31%	5%	3%	-36%

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.

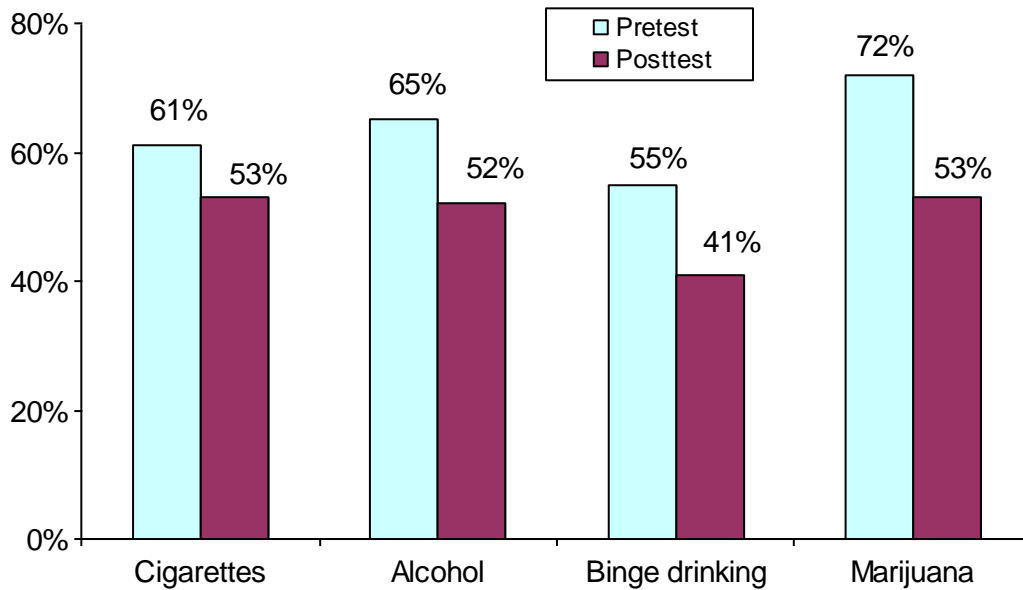
Ian—Becoming a Leader and Role Model

Ian describes himself as “strong, kind of smart, and funny.” He was referred to the intervention specialist by the school counselor after getting into several fights in and out of school. Ian lives with his grandparents because his parents were unable to control him. Ian began participating in a social skills class that teaches anger management and problem solving techniques and encourages students to identify and communicate their feelings, follow rules, and remain alcohol and drug free. Ian, who has not been involved in any incidences of violence in or out of school since he began participating in the social skills class and dealing with his anger, has become a leader and role model for other students. His behavior is more kind, generous, and helpful and he is more confident about himself and his decisions. Ian’s academic performance has improved and he has become active in school sports. Encouraged by his progress, Ian’s parents have asked him to return home. Ian reports that the intervention specialist helped him change his attitude. Rather than fighting, he now just walks away.

Heavy Substance Use

Program 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. Exhibit 18 demonstrates that the percentage of these students who reported using tobacco, alcohol, marijuana, and binge drinking in the past month declined notably over the course of the year.

Exhibit 18
Substance Use Among Students Meeting Criteria on GAIN-SS



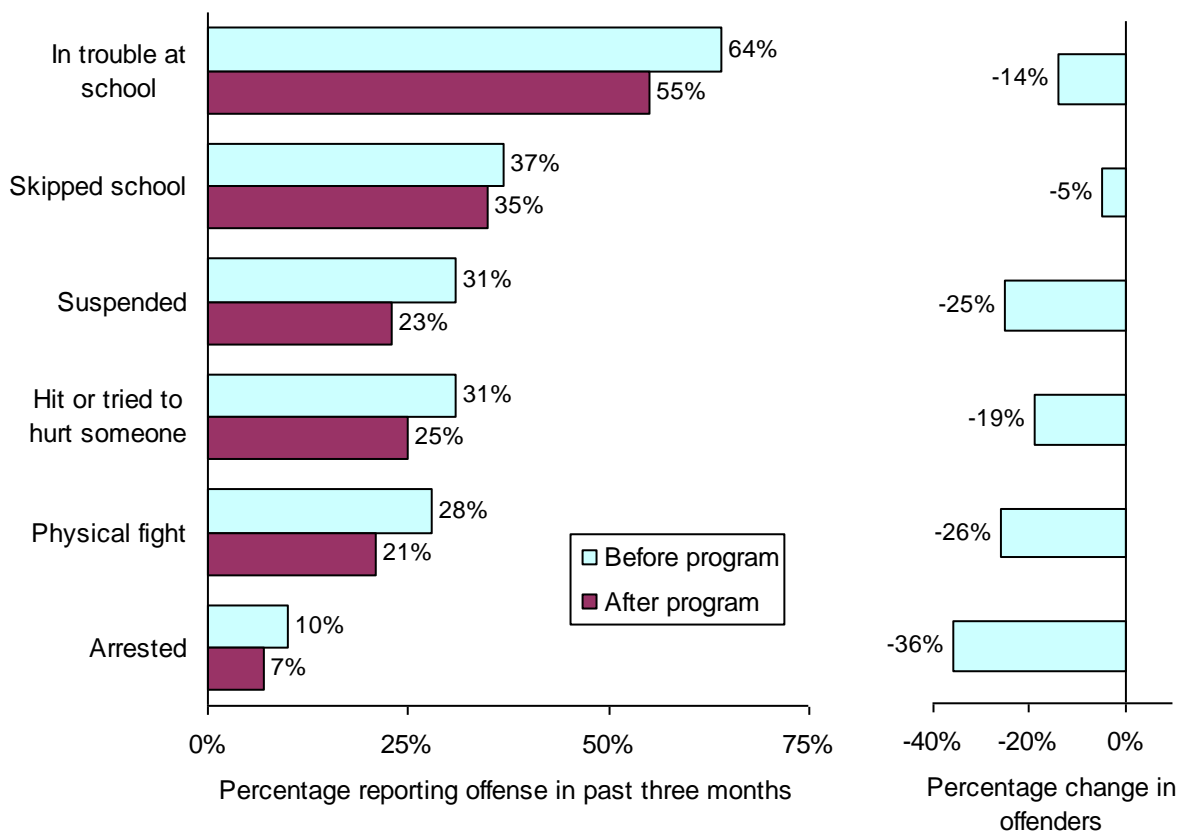
Note. $n = 1,489$.

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 increased dramatically following various shooting incidents in schools across the country.

Students with a behavioral intervention goal who completed both the pretest and posttest in 2010–11 ($n = 2,405$) were less likely to report antisocial activity in the past three months after participating in the program (see Exhibit 19). A statistically significant reduction in the prevalence of each antisocial behavior, except being arrested, 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 64 percent to 55 percent, and the percentage of students who reported being involved in a physical fight in the past three months decreased from 28 percent to 21 percent after participating in the program.

Exhibit 19 Antisocial Behaviors



Note. n = 2,405.

To illustrate the importance of these changes in another way, Exhibit 19 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 14 percent reduction in the number of offenders. Likewise, the net reduction in physical fighting was 26 percent.

Frank—Positive Life Decisions Leading to Academic Improvement

Frank is a 17-year-old senior in a small suburban community. He has overcome years of drug problems and has used participation in football, wrestling, and track to help him refocus his life and make new friends who do not use alcohol or drugs. He relates how failing a drug test his junior year and receiving a drug assessment caused him to want to straighten out his life. He comments, "I didn't want to graduate and just end up living with my friends and partying all the time." Frank said that he almost dropped out of high school but counselors helped him with his academics and the intervention specialist "helped me with mental stuff."

Frank participates in individual counseling with the intervention specialist where they discuss life situations and problems. He has also participated in elementary school assemblies about making choices and in high school assemblies during Drug Awareness Week. He also said that he has done some community service work to improve his reputation. Frank relates how working with the intervention specialist has helped him figure out what is important and unimportant to him, and he has decided he wants to go into the Marines.

According to Frank, working with the intervention specialist has helped him learn coping and anger management skills, decision-making skills and thinking through problems, and helped him completely change his peer group. He also relates the dramatic improvement in his grades from "a 2.0 to being on the honor roll." Frank says that now his mother has more respect and trust in him and teachers and coaches see the changes he has made. Frank concludes, "It's been good having someone to talk to and turn to, the intervention specialist provides help when I need it."

School Success

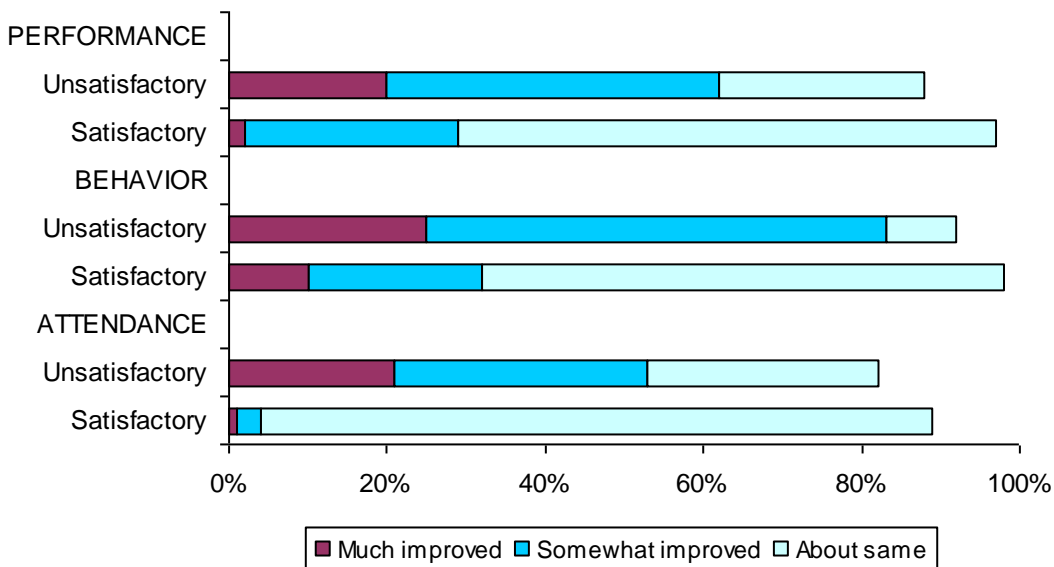
Research has shown that low grades, poor attendance, disruptive school behavior, and low commitment to school are risk factors for substance use and other risky behaviors (Hawkins et al., 1992). These factors are among the most common reasons for referring students to a student assistance program. The relationship between substance use, program participation, and school performance is, however, complex. Local programs 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 if 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 can 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.

In the 2010–11 school year the evaluation considered the impact of SAPISP for students in elementary and alternative schools on three school success outcomes: academic performance, attendance, and school behavior. These school success outcomes were collected through teacher ratings.

Teacher Ratings

If a student receiving program services does not receive letter grades for classes, the number of classes passed and failed cannot be used as a measure of the program's impact on his or her academic performance. In only such cases—usually involving elementary and alternative school students—intervention specialists ask a teacher to rate each student's classroom performance, behavior in school, and attendance on a five-point scale from *much worse* to *much improved*. Exhibit 20 shows the teachers' ratings in 2010–11.

Exhibit 20
Teacher Ratings



Note. $n = 1,260$.

Teachers provided ratings in each domain for students before and after program participation. Students rated with unsatisfactory classroom performance before the program were rated after the program as having much improved or somewhat improved classroom performance in 20 percent and 42 percent of the cases, respectively. At least some improvement was also observed for 30 percent of those students with satisfactory performance before program participation.

Students rated with unsatisfactory behavior in school before the program were rated after the program as having much improved or somewhat improved behavior in 25 percent and 58 percent of the cases, respectively. Improved behavior in school was also observed in 32 percent of the students with satisfactory behavior before program participation.

In addition, students rated with unsatisfactory attendance before the program were rated after the program as having much improved or somewhat improved attendance in 21 percent and 32 percent of the cases, respectively. Improved attendance was also observed in 4 percent of the students with satisfactory attendance before program participation.

Longitudinal Follow-Up

RMC Research conducted a longitudinal study that tracked grade and attendance data over three years for a random sample of approximately 20 percent of the students participating in SAPISP during the 2007–08, 2008–09, and 2009–10 school years. In 2010 a significant change pertaining to the collection of follow-up data was implemented. OSPI elected, with support from Washington’s Division of Behavioral Health and Recovery, to discontinue the aforementioned approach in favor of collecting longitudinal data on the number of classes passed and the number of classes failed for all students receiving at least three contacts with an intervention specialist. Baseline data is collected for the first academic term of the current school year and follow-up data is collected for the first academic term of the subsequent school year. This approach is less burdensome for intervention specialists and serves as a broader and more meaningful measure of SAPISP impacts on student performance. OSPI’s investment in collecting follow-up data on all program participants reflects a commitment to connect substance use prevention and intervention services to schools’ core function of promoting academic achievement.

The first implementation of this change involved students served during the 2010–11 school year. For these students intervention specialists reported baseline data from fall 2010 and are currently collecting follow-up data from fall 2011. The follow-up data for 2010–11 were not available for this report but will be included in the 2011–12 annual report.

Nicole—Staying Clean

Nicole, a high school freshman, seems mature and insightful for her age—she describes herself as “the responsible one.” Nicole has a history of extensive alcohol and drug use and running away from home. She now lives in a foster home but maintains contact with her family. Nicole says she feels confused and unhappy most of the time. She self-referred to the intervention specialist because she was experiencing peer relationship problems and was fearful of being attacked by other students. The intervention specialist met with Nicole and referred her to a mental health counselor for her depression. Nicole is staying clean and the intervention specialist helped her join the local Y to swim. She began to focus on academics and reports that she is no longer afraid to go to school because she has learned to distance herself from the petty fights and gossip. Her school attendance, classroom behavior, and grades have improved significantly. Nicole has stopped running away and has begun to work through her family issues.

Limitations

The program effectiveness findings are encouraging, but certain limitations of the data should be considered. First, most of these results are based on student self-report. Research has shown, however, 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 survey at both points in time. Examples of reasons given for students participating in the program without completing the survey at both points in time included; (A) the student was in crisis and could not be pretested; (B) it was not possible to obtain release time for the student to complete the pretest or posttest, and; (C) 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 include students with low program 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). To provide additional longitudinal outcome data on program participants, SAPISP is currently tracking the number of classes passed and the number of classes failed for all students receiving at least three contacts with an intervention specialist. The follow-up data for 2010–11 program participants will be included in the 2011–12 annual report.

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 are 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

Overall, the results of this evaluation reflect favorably on the effectiveness of SAPISP. Local programs have historically served about 600 to 700 schools annually though reductions in program funding limited the program to serving just over 300 schools in 2010–11. Between 16,000 and 20,000 students have historically benefited annually from indicated or selective preventive intervention activities supported by program funds. In 2010–11 the number of students receiving these intervention services dropped to less than 12,000. The outcome assessment continues to provide 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 and substance use.

Despite these positive results, preserving a minimum level of service and fostering positive change is a major challenge due to drastic reductions in funding. The severe economic climate has negatively impacted the funding available to support the program, which has in turn reduced services. 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 were enacted for 2010–11 and a statewide prevention redesign will target program services to fewer schools in the coming years. Clearly, some difficult planning will be needed to weight the various objectives of SAPISP to determine how to sustain these valuable program services at some basic level across the state.

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