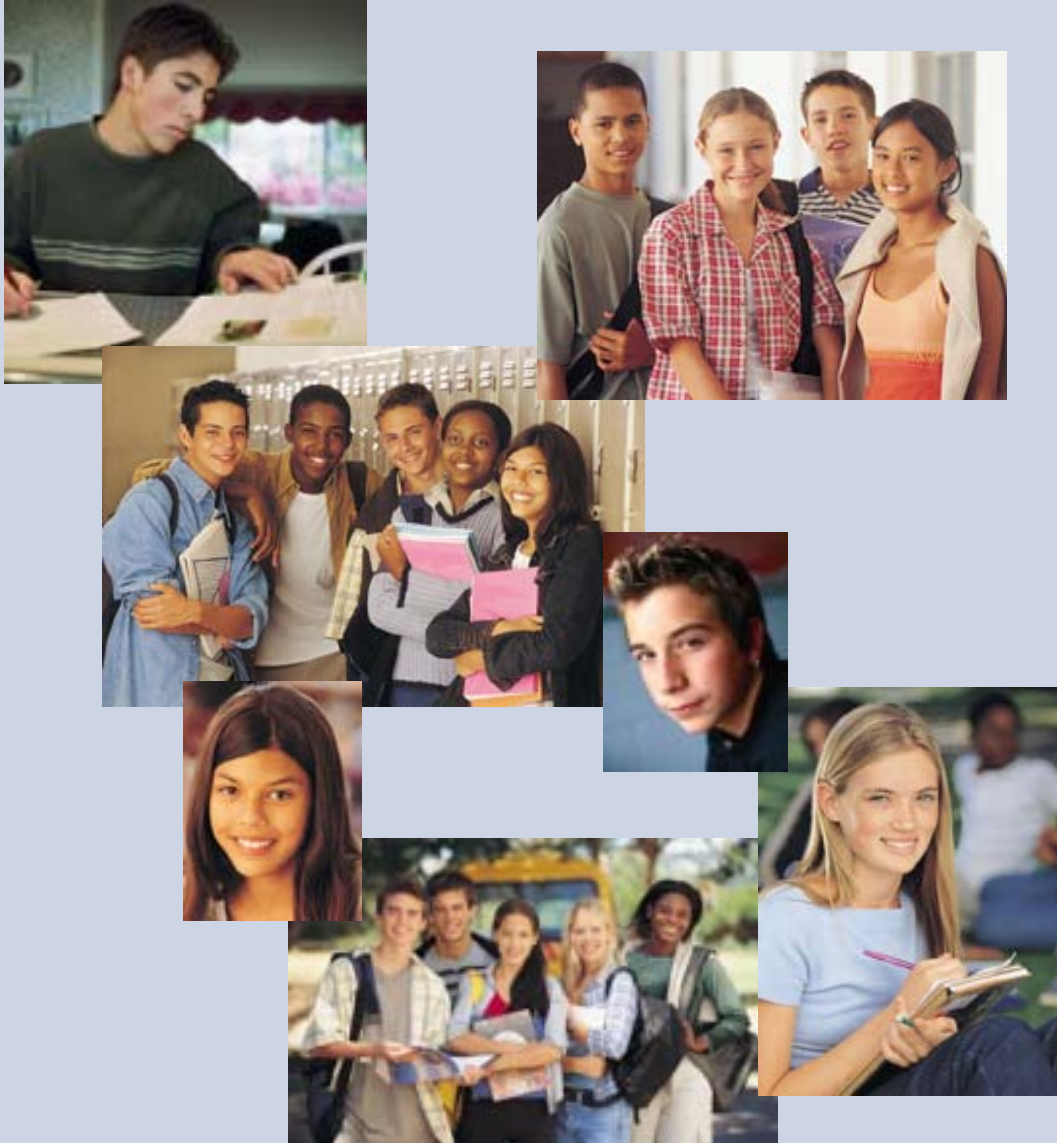


Retrospective Analysis of the Pennsylvania Student Assistance Program Outcome Data



*Implications for
Practice and Research*

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Retrospective Analysis of the Pennsylvania Student Assistance Program Outcome Data: *Implications for Practice and Research*

Executive Summary



Student Assistance Programs (SAP) are a primary vehicle for schools in Pennsylvania and across the nation to address students' behavioral health needs and concerns. SAP identifies and links students to behavioral health care education, programs and services in the school and community to address students' barriers to learning due to a social, emotional or mental health concern or problem. To contribute to the SAP research base and to document their effectiveness, the Research Committee of the National Association of Student Assistance Professionals conducted a retrospective analysis of SAP data collected as part of the Pennsylvania Student Assistance Program evaluation. The current study has implications for the Student Assistance field and provides a foundation for future research at the local, state and national level.

In the current study, four types of behavioral health care system outcomes were examined: recommended and accessed school programs and services, recommended and accessed community programs and services, core team recommendation for an agency assessment, and agency assessment recommendations. Students are consistently linked through SAP to the behavioral health care system, and at a higher rate than is reported nationally (U.S. Surgeon General,

2001, Ringel & Sturm, 2001). Many students coming through a Student Assistance Program are referred to a community human services agency for an assessment. A majority of the students who are linked to and assessed at the local agencies comply with the assessment recommendation and access some if not all the recommended programs and services.

Positive student outcomes are evident for students who participate in the Student Assistance Program. Students who participate in a SAP are expected to attend school, behave and progress academically. The specific student school outcomes examined in the current study are student attendance, suspension (for behavior or drug/alcohol policy violations), and promotion, retention and graduation status after their SAP referral. Referred students show positive improvements in attendance, a decrease in discipline problems (as measured by additional suspension rate) and positive promotion and graduation status after their SAP referral. ■

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Introduction

In July of 1998, the Pennsylvania Commission on Crime and Delinquency (PCCD) funded an initiative to evaluate Student Assistance Programs (SAP) in Pennsylvania. The primary goal of the evaluation was to determine the overall efficacy of the state's SAPs. This evaluation investigated six areas of student assistance programs and developed a framework to guide future evaluations. The six areas were:

- **SAP referral processes**
- **Parent consent practices**
- **Intervention services**
- **Contract provider assessments**
- **School-based probation officers' SAP involvement**
- **SAP improvement and satisfaction**

The conclusions of the first year of study as outlined in the Evaluation Report (Fertman, Schlesinger, Fichter, Tarasevich, Zhang & Wald, 1999) are as follows:

- A defined, well-communicated referral process is operational in most of the teams, and the potential referrers know how to access and utilize the student assistance team.
- SAP teams contact and involve parents in the process. In cases where parents refuse SAP services, the primary reasons include denial that a problem exists and privacy issues.

- SAP teams make recommendations for a variety of services including assessments, and are monitoring students on an ongoing basis.
- Behavioral health liaison services (drug and alcohol, mental health, positive youth development) are in place providing preliminary assessment and linkage with service providers.
- An increasing number of schools are receiving services from school-based probation officers. Their involvement in SAP is evolving in accordance with the changing times in school settings. These officers have specialized knowledge of a limited student population. Initially their participation was limited to their professional role and function. Currently their role is expanding to become a skilled resource to the team.
- While currently not extensively practiced, the assessment of parent and student satisfaction has the potential to contribute to the continued quality improvement of SAP.
- Team members and county administrators provided suggestions for improvement of SAP. However, their prioritization of suggestions reflects their role in the SAP process.

In July of 1999, the PCCD and Pennsylvania Department of Education funded a continuation of the initiative in order to identify essential components related to SAP, delineate indicators for each component area, identify factors related to exemplary and struggling SAP teams and outline a benchmarking process for technology





transfer and continual improvement of SAP (Fertman, Schlesinger, Fichter, Tarasevich, Zhang & Wald, 2000).

The activities accomplished in the second year of the study include:

- Literature review of SAP and adolescent risk factors.
- Identification of essential components of SAP based on literature review and Year 1 results.
- Delineation of specific indicators of effective SAPs via focus groups, site visits and analysis of Year 1 data.
- Site visits of exemplary and struggling teams.
- Establishment of specific components and indicators.
- Development of a common unit of analysis to link data sources.
- Development of user-friendly written materials explaining the utilization of benchmarks and indicators.
- Development and delivery of a training module for the Commonwealth Approved Training System.

The completion of the Pennsylvania evaluation in July 2000 coincided with an interest to strengthen the research base of Student Assistance Programs. In the 1970s and 1980s the growing interest in drug and alcohol and mental health problem prevention fueled the design, development, implementation, and evaluation of researched interventions to address students' social, emotional, and mental health needs. A defining moment for schools and commu-

nity agencies was passage of the Principles of Effectiveness (*Table 1*) as part of the 1998 Safe and Drug-Free Schools and Communities Act (SDFSCA) and reauthorized and modified in No Child Left Behind Act of 2001: Title IV—21st Century Schools Part A—Safe And Drug-Free Schools and Communities.

The Principles of Effectiveness addressed a universal concern for effective and accountable programs to meet students' behavioral health needs and concerns. Due to the Principles of Effectiveness, for the first time funds were linked to schools' and communities' implementation of programs aimed at students' needs that were theory-based and proven effective by research. They had the effect of pushing schools and communities to think strategically about allocating resources to address the behavioral health needs of specific target student populations. The Principles require that the program or activity undergo a periodic evaluation to assess its progress toward reducing violence and illegal drug use in schools. Furthermore, the results of the evaluation are to be used to refine, improve, and strengthen the program, and to refine the performance measures.

In response to the Principles of Effectiveness, several initiatives were undertaken by national organizations and Federal agencies to identify programs that meet the Principles' standards. The programs identified through these initiatives have a largely "academic" orientation, with an emphasis on curricula, activities and psychoeducational processes for specific populations.

- A. Programs be based on an assessment of objective data regarding the incidence of violence and illegal drug use in the elementary schools and secondary schools and communities to be served, including an objective analysis of the current conditions and consequences regarding violence and illegal drug use, including delinquency and serious discipline problems, among students who attend such schools (including private school students who participate in the drug and violence prevention program) this is based on ongoing local assessment or evaluation activities;
- B. be based on an established set of performance measures aimed at ensuring that the elementary schools and secondary schools and communities to be served by the program have a safe, orderly, and drug-free learning environment;
- C. be based on scientifically based research that provides evidence that the program to be used will reduce violence and illegal drug use;
- D. be based on an analysis of the data reasonably available at the time, of the prevalence of risk factors, including high or increasing rates of reported cases of child abuse and domestic violence; protective factors, buffers, assets; or other variables in schools and communities in the state identified through scientifically based research;
- E. include meaningful and ongoing consultation with and input from parents in the development of the application and administration of the program or activity.

**TABLE 1: SAFE AND DRUG-FREE SCHOOLS PRINCIPLES OF EFFECTIVENESS
(U.S. Department of Education, 1998, 2001)**

To a large degree they are developed in universities through demonstration grants and research studies. For example, The Center for the Study and Prevention of Violence at the University of Colorado at Boulder initiated a project to identify violence prevention programs (Blueprints). Specific programs may be obtained at its website: <http://www.colorado.edu/cspv/>. The Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration (SAMHSA) focused on substance abuse and violence prevention programs, with an emphasis on enhancing protective factors. More information for these programs is at the website: <http://www.modelprograms.samhsa.gov>. The Safe and Drug-Free Schools Program represents an effort by the federal government to reduce violent behavior and drug, alcohol, and tobacco use through education and

prevention activities. Information on exemplary and promising safe, disciplined and drug free schools is available at the U.S. Department of Education Office of Safe and Drug Free Schools (1-877-4ED-PUBS). Most recently in March of 2003, the Collaborative for Academic, Social, and Emotional Learning (CASEL) focused on social and emotional learning and produced “Safe and Sound” an educational leader’s guide to evidence-based social and emotional learning programs (www.CASEL.org).

Work on the research base of Student Assistance Programs developed along a number of different fronts. It identified different SAP models (Moore & Forster, 1993, 1988; Morehouse, 1989; Tarasevich, 2001), described the SAP process (Fertman, Schlesinger, Fichter, Tarasevich, Zhang & Wald, 2001), and established the relationship



between lower overall student drug use in a school and the presence of an SAP in that school (Scott, Surface, Friedli & Barlow, 1999). Project Success and the Residential Student Assistance Program (www.sascorp.org), with their roots in the Westchester County Department of Community Mental Health Student Assistance Program, successfully completed the research protocols to be approved as SAMHSA Model Program Universal Interventions (Schinke, Brounstein, & Gardner, 2002). The Westchester SAP is an externally based SAP model relying on a community agency to provide staff and leadership for the day-to-day SAP operations. Likewise, the Team Awareness Program (www.organizationalwellness.com), based on workplace Employee Assistance Programs (EAP), was researched and established as a model program (Schinke, Brounstein & Gardner, 2002). The Pennsylvania SAP evaluation (Fertman et al, 2000) and evaluations of the STARS program in Tennessee (Hepler & Renfro, 2003) represent research on a Student Assistance Program model that has its roots in a school team based model first proposed and used in schools starting in the late 1970s (U.S. Department of Education, 1984).

It was clear from the SAP research that while SAP has certain qualities that enables it to fit within the SAMHSA model program rubric, and that such recognition is desirable, SAP can also be conceptualized as more than a program. The SAP process links education, programs and services within and across systems. SAP is not a curriculum that a teacher or counselor uses

with, say, a group of seventh graders during second period on Tuesday morning. It is a process of assessing and matching students' and families' needs with education, programs and services within the behavioral health care system.

Trying to learn more about the SAP process and model a research agenda for the Student Assistance field, the current retrospective study investigates secondary school student outcomes from participation in the Student Assistance Program in Pennsylvania. The study builds on the work of Adelman and Taylor (2002) by investigating behavioral health program outcomes as well as school indicators consistent with the intent of SAP. Student linkages to the behavioral health care system education, programs, and services are examined first. SAPs do not treat students; rather, they link students and their families to behavioral health education, programs, and services. School outcomes in terms of attendance, suspensions, and grade promotion, graduation or retention after SAP participation are examined second. The retrospective study was undertaken to model a research methodology for school team based Student Assistance Programs that uses existing local data and can be implemented across elementary, middle, and high school settings. The study has implications for the Student Assistance field. It provides a foundation for future Student Assistance Program research at the local, state, and national level.

Need for Student Assistance Programs

“Behavioral health” encompasses social, emotional, and mental health. Social changes that began in the 1960s and gained widespread attention by the 1980s affected the lives of children and teenagers, and are reflected by changes in their behavioral health. A series of reports and studies documented well the stresses from poverty, homelessness, substance abuse, restructuring of families, corporate downsizing, physical and sexual abuse, and domestic and community violence that became a normal part of the family and neighborhood culture within which many young people grew and developed (Commission for the Prevention of Youth Violence, 2000; Surgeon General, 2000, 2001). As a result of these stresses, Dryfoos (1998) suggested that 25% of American youth are extremely vulnerable and 25% are moderately vulnerable to the negative consequences of engaging in multiple high-risk social and health behaviors. The remaining 50%, who are currently at low risk for engaging in such behaviors, may nonetheless require strong, ongoing support to avoid such involvement (Consortium on the School-Based Promotion of Social Competence, 1994). Behavioral health reflects the pervasiveness of stress in the lives of people, and the interrelationship and co-morbidity of social, emotional, and mental health issues and concerns.

In making the argument for behavioral health education, programs, and services in schools, proponents focus on the gap between children and adolescents’ behavioral

health needs and utilization of behavioral education, programs and services. Although reported statistics vary, it is generally agreed that as many as 80% of youth in need of behavioral health services may not receive them (U.S. Surgeon General, 2001; Ringel & Sturm, 2001). For example, older adolescents with mental health problems, urban youth, and special education students have been identified as underserved populations (Cohen & Hesselbart, 1993; Stiffman, Earls, Robins & Jung, 1988; Costello, 1989).

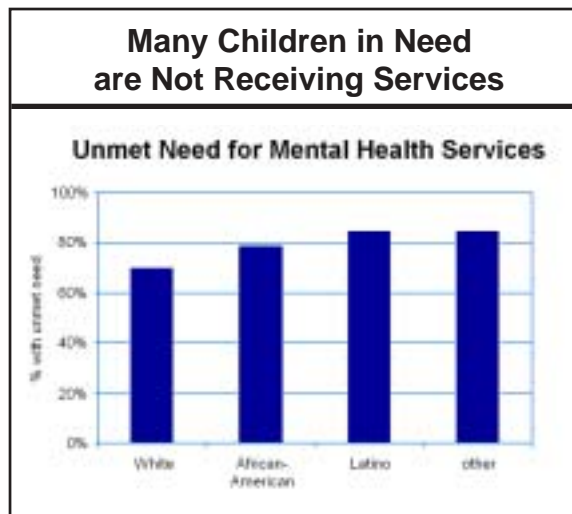


FIGURE 1
UNMET NEED FOR MENTAL HEALTH SERVICES
(Ringel & Sturm, 2001)

Historically, behavioral health services have been disproportionately provided to only the most severely impaired (Cowen, Hightower, Pedro-Carroll, Work, Wyman & Haffey, 1996). Furthermore, disparities in services to youth from different cultural groups have been identified (*Figure 1*). Ringel and Sturm (2001) reported low utilization of service for most youth, with African American and Latino youth in particular reporting



low access to programs and services. Therefore, it is argued that integrating behavioral health education, programs, and services into schools will increase their utilization by the general population of students, less-impaired youth as well as severely impaired youth, who did not previously access care (Evans, 1999).

The growing recognition of the behavioral health needs of youth has been the impetus for various sectors to design and implement behavioral health education, programs, and services to meet those needs (U.S. Surgeon General, 2001). Education, programs, and services across the behavioral health system address a range of students' needs from the perspectives of behavioral health promotion and problem prevention to intervention with students with moderate to severe behavioral health problems (Policy Leadership Cadre for Mental Health in Schools, 2001; Shin, 2001; Pfeiffer & Reddy, 1998; Nastasi, 1997).

From a practical point of view, school and community agency staffs need to know all the community and school behavioral health education, programs, and services that serve students (*Figure 2*). Many of the education, program, and service resources that exist together were developed in the 1980s and 1990s and reflect a biopsychosocial model of social, emotional, and mental health. Consequently, a variety of behavioral health problem prevention, intervention and treatment approaches and models are now available such as medications, family education, mobile therapy, day treatments, 12-step approaches, and cogni-

tive-behavioral therapy (Kaminer, 2001). Reflecting the biopsychosocial model, behavioral health education, programs, and services in the community have moved beyond the traditional inpatient and outpatient models to embrace a range of innovative approaches. Likewise, whereas substance abuse and mental health services were restricted to problem treatment, today many programs and services focus on social, emotional, and mental health promotion and problem prevention. Examples include screenings, consultation and education, SAMHSA model programs, and alternative activities. Another change is the active involvement of organizations serving youth, such as 4H Clubs, Boys and Girls Clubs, self-help groups, and faith-based organizations in the behavioral health care service system, particularly in the areas of promotion and problem prevention.

Programs and services such as those listed in *Figure 2* are the products of a system of care constructed by many stakeholders. Families, youth, teachers, counselors, nurses, community members, clergy, child-care workers, principals, public officials, and lawyers are just some of the many who need to come together to identify gaps in the system, advocate for funding, champion the need, and design, implement, and staff the programs and services. Schools and communities need to work to develop and engage as many of these programs and services as possible to address the behavioral health needs of the students.

Student Assistance Programs link youth and families to the behavioral health care

system education, programs, and services. SAPs confront the barriers to learning erected in the lives of children and adolescents by substance abuse and mental health problems. The concerns and problems facing many families and youth are too numerous and large for families and young people to successfully confront and ameliorate. Plus, navigating the behavioral health care system with its fragmentation, diverse funding streams, and eligibility requirements, adds a layer of complexity that often is a barrier in itself. SAP provides the support and links for schools, communities, families and youth to work together to remove the barriers.

School Team Based Student Assistance Program

In the current study we investigate the school team based Student Assistance Program commonly known as the core team model. The core team is interdisciplinary with teachers, counselors, administrators, nurses, health educators and community agency liaisons from behavioral health programs and services (e.g., drug and alcohol, mental health, positive youth development) that work with the team at least once per week. Leadership of the team is collaborative, with one person, typically a coordinator, usually responsible for operation, planning and evaluation of everyday team activities. The team is under the supervision of a building administrator who works closely with them.

The backbone of the school's efforts to address students' behavioral health problems are the policies, procedures and guidelines that outline best practices for the team specifically (and educators in general) when responding, for example, to a suicide threat or the suspected possession or use of alcohol, tobacco or other drugs. The school board approved policy and administrative procedures clearly delineate the consequences associated and aim to reduce such occurrences in school. In states such as Pennsylvania, a detailed set of guidelines for core teams (with training standards and core competencies as well) delineate the skills and knowledge essential for effective core team function. These documents serve to systematize practice at the local school level.

The core team model utilizes a teacher-responsive four-phase process that includes the consent and participation of parents as well as students. Through the process, students and their parents are linked to community and school behavioral health education, programs and services. The SAP phases are referral, team planning, intervention and recommendations, and follow-up and support (*Figure 3*).

Referral Phase: The first phase of the Student Assistance process involves problem recognition, referral, initial fact-finding, and parent contact and participation. The common warning signs associated with barriers to learning that may be referred to SAP include poor school attendance, lowered academic performance, and discipline and behavior as well as health-related concerns.



Type of Service	Program Characteristics
Screenings	<ul style="list-style-type: none"> ◆ On-site (e.g. school, community center, workplace) mental health screening and information
Community Coalitions	<ul style="list-style-type: none"> ◆ Broad based community representation ◆ Community needs assessment to identify system gaps ◆ Program and service design, implementation and evaluation
Family Networks	<ul style="list-style-type: none"> ◆ Advocacy ◆ Innovative education, programs and services
Family School Collaborative	<ul style="list-style-type: none"> ◆ Youth centered, family focused and driven ◆ Strength-based ◆ Community based/least restrictive environment
Consultation & Education Services	<ul style="list-style-type: none"> ◆ Policy and procedure review and development ◆ Mental health education and program planning, implementation and evaluation ◆ Staff training ◆ Parent education and information
SAMHSA Programs	<ul style="list-style-type: none"> ◆ Targeted populations ◆ Meet Principles of Effectiveness
Case Management	<ul style="list-style-type: none"> ◆ Individual case support and management
Alternative Activities	<ul style="list-style-type: none"> ◆ Mental health promotion activities focused on social competency and support
Inpatient Psychiatric Care	<ul style="list-style-type: none"> ◆ Short term (typically less than two weeks) care in psychiatric hospital due to crisis ◆ Emergency room service, crisis support ◆ Evaluation and treatment recommendation
Emergency Services	<ul style="list-style-type: none"> ◆ Crisis situation intervention to aid and advise ◆ Emergency numbers operate 24 hours a day
Supportive Counseling	<ul style="list-style-type: none"> ◆ Traditional outpatient counseling ◆ Individual, group, family, and couple formats
Day Treatment (Partial Hospitalization)	<ul style="list-style-type: none"> ◆ Falls in the middle of continuum of care, between inpatient and outpatient ◆ Setting varies from hospital-based to school-based ◆ Considered most intensive of long-term, non-residential MH services available to children ◆ Can include special education, counseling, vocational, crisis intervention, recreational
Day Treatment Models in Schools	<ul style="list-style-type: none"> ◆ Educational assessment and planning ◆ Special schools that provide full-day educational programs ◆ On-site mental health services linked to in-home services for families and full-time residential schools
Therapeutic Foster Care	<ul style="list-style-type: none"> ◆ Least restrictive form of care among residential services ◆ Provides treatment for troubled children within private homes of trained families ◆ Combines family-based care with specialized treatment
Complementary and Alternative Medicine	<ul style="list-style-type: none"> ◆ Body mind focus ◆ Holistic approaches focused on stress management and wellness
Self Help Groups	<ul style="list-style-type: none"> ◆ Community based peer and social support ◆ Assistance for seeking help and referral ◆ Sense of belonging
Faith-based Programs	<ul style="list-style-type: none"> ◆ Individual, group, family and couples counseling based on religious principles ◆ Addresses spiritual concerns ◆ Prayer is integral part of the programs
Youth Corrections	<ul style="list-style-type: none"> ◆ Designed for youth on probation for minor offenses or youth who have been adjudicated through the courts ◆ Some corrections programs take form of wilderness-type programs, while others are secured residential programs

Home-Based Services (Mobile therapy)	<ul style="list-style-type: none"> ◆ Delivered primarily in family’s home; also available in other community settings ◆ Committed to family preservation and reunification ◆ “Ecological” perspective and involve working with the community ◆ Service delivery hours are flexible to meet needs of families ◆ Multifaceted services; education, counseling, skill training, etc.
Respite Services	<ul style="list-style-type: none"> ◆ Provided both in child’s home and in out-of-home settings by trained respite providers
Residential Treatment	<ul style="list-style-type: none"> ◆ Extended treatment in restricted setting ◆ Multifaceted services; education, counseling, skill training, etc.
Group Homes for Specific Populations	<ul style="list-style-type: none"> ◆ Created for children and adolescents who cannot function in the family setting, but do not require institutional or residential care ◆ Child is maintained in the community and continues to be involved in community life up to his/her best ability ◆ Typically limited to eight or fewer residents
Independent Living	<ul style="list-style-type: none"> ◆ Residential programs helping young adults ages 18 to 25 successfully achieve independence ◆ Assist youth in planning for education and career; and working to resolve personal and family problems

FIGURE 2
TRADITIONAL AND INNOVATIVE YOUTH BEHAVIORAL HEALTH PROGRAMS AND SERVICES
(adapted from Lewin Group, 2000)

The team gathers objective information from all parties who work with the student in an effort to define the difficulty. During this phase of the process, the team does some initial fact-finding to ascertain if SAP is the best resource to help the child, and if the referral was appropriate. Central to the Pennsylvania SAP process is the contact, consent and participation of parents in the process. The observations made by parents of their children are seen as a crucial part of the process. It is the parent’s right to be involved in the process and to have full access to all school records under applicable state and federal laws and regulations.

Involvement of parents in all phases of the Student Assistance Program underscores their role and responsibility in the decision-making process affecting their children’s education and is the key to the successful resolution of problems (Pennsylvania

Department of Education, 1997). Parental contact is defined as communication between the school SAP team by telephone, letter, or meeting. Parental participation is defined as the active involvement of parents in making the decisions that affect their child.

Team Planning Phase: During team planning, the team gathers objective information about the student’s performance in school from all school personnel who have contact with the student. Teachers, counselors, school nurses, coaches, and activity moderators may see early warning signs, that when addressed can prevent more serious consequences. Initially, a team member will talk with the parents. Likewise, conferences with the student are held to understand the student’s perception of the problem. Finally, with parent and student input, a plan is developed that includes

strategies for removing the learning barriers and promoting the student’s academic and personal success.

Intervention and Recommendation

Phase: In the intervention and recommendation phase, the plan is put into action. The team makes recommendations and attempts to link students to in-school and community-based services and activities. In the majority of cases, students are referred to in-school services, resources, and activities. Among these resources and activities are: one-to-one mentoring with a school support person (e.g., a health teacher or guidance counselor); participation in life-skill development groups such as anger

management; and learning effective decision making, communication skills, and academic/learning strategies. Students are frequently linked to existing school activities and student groups (e.g., peer mediation and intramural activities).

Students may also be referred to community human service agencies. It is common to recommend an assessment (e.g., of drug or alcohol use, mental health, or depression) at the agency. The community agency’s staff member who serves as a team member and liaison between the agency and school is critical to this phase. Typically, the community agency staff member works in

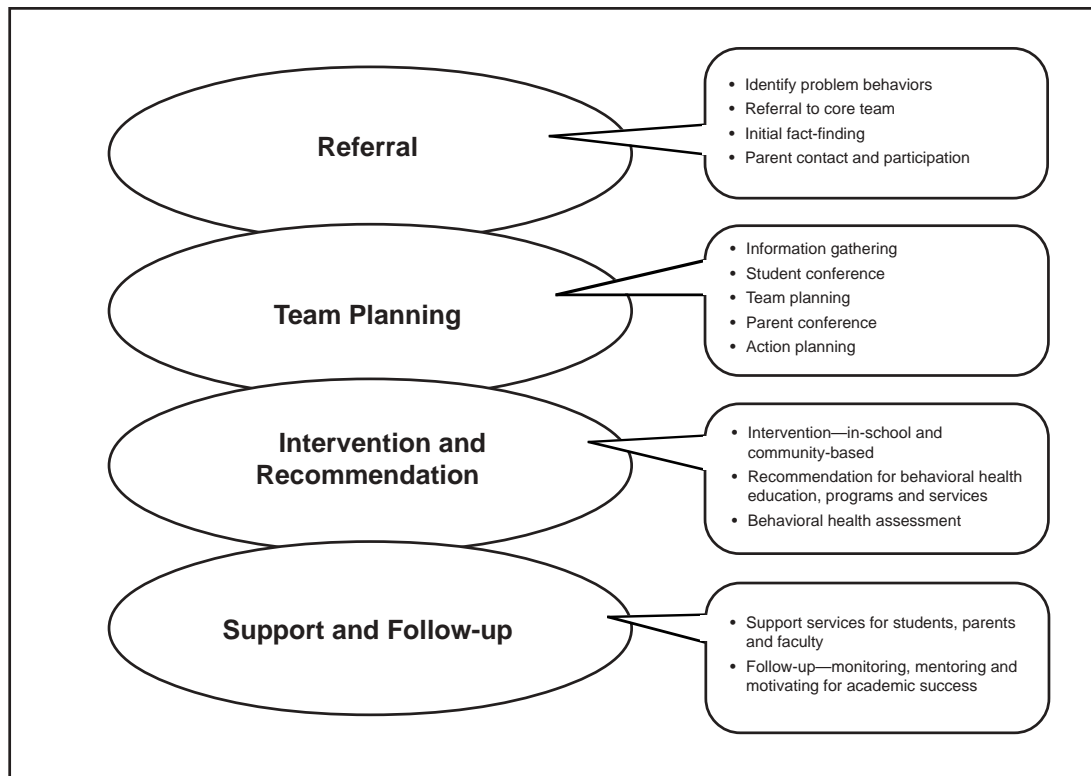


FIGURE 3
PENNSYLVANIA STUDENT ASSISTANCE PROGRAM PROCESS MODEL
 (Fertman, et al, 2001)

the school for a designated amount of time each week. In most schools, it is these professionals who provide the assessment. Frequently, they will also provide educational support groups and technical assistance to SAP teams (Pennsylvania Department of Public Welfare, 1997). The agency staff provides a link to the behavioral health care system in the community.

SAP teams do not provide mental health and drug and alcohol assessment, evaluation or treatment. The student assistance team members do not diagnose, treat or refer for treatment; but they may make a recommendation for an assessment. Student Assistance team members are trained to identify problems, determine whether or not the presenting problem lies within the responsibility of the school, and make recommendations to assist the student and the parent. In cases where the problem lies beyond the scope of the school's responsibility, it is the team's responsibility to inform the parent of the problem affecting the child's performance in school, provide information on community resources and the options to deal with the problem, and, where necessary, establish links with resources to help resolve the problem. For those students receiving treatment through a community agency, the team, in collaboration with the parent and the agency, plans in-school support services during and after treatment (Pennsylvania Department of Education, 1997).

Support and Follow-up Phase: The support and follow-up phase facilitates the student's participation throughout the

change process. In addition, should the child require a higher level of care than initially recommended, the team can provide the necessary documentation and linkage to promote this. Support is also provided to parents and staff so that they can work together to promote the student's success.

Methodology

The study design is a three-year retrospective analysis of secondary school (middle and high school) student participants in one district SAP for the school years 1998-1999 (98/99), 1999-2000 (99/00), and 2000-2001 (00/01).

The study sample consisted of secondary school students from the district who participated in its Student Assistance Program for each of the three years (*Table 2*). Over the period of the three years more females were referred to the SAP than males. Statewide SAP student demographics for the three-year period averaged 54% male and 46% female. A significant proportion of the students were special needs students. Combining both special education and gifted education referrals, special needs students accounted for 20 to 25% of all referrals to SAP. For the state of Pennsylvania the statewide percentages are 18% for special education students and 3% for gifted students during the same years.

Across the three years the largest percentages of students referred on average are in grade nine (19%). The smallest percentage of students referred were in



School year	1998-99	1999-2000	2000-01
Total Referrals	2,581	2,850	3,140
Males	1,168 (45%)	1,296 (46%)	1,496 (48%)
Females	1,405 (55%)	1,515 (53%)	1,629 (52%)
Special Education	372 (14%)	485 (17%)	565 (18%)
Gifted Education	148 (8%)	86 (3%)	189 (6%)

TABLE 2
STUDENT SAP DEMOGRAPHICS: 98/99, 99/00, and 00/01

grade 12 (11%). The remaining referrals were evenly divided among grades six, seven, eight, ten, and eleven. The SAP program also assists girls who become pregnant. In close collaboration with the Teen Pregnancy Prevention and Intervention program, all Youth Advocates from this program are SAP trained and actively participate on core teams. SAP teams link the young women to tutoring and support services throughout the pregnancy and after the birth of the child. For the three school years the district reports that on average 11% of referrals received in school were for

teen mothers. This may account for the higher number of females referred to SAPs.

Since school year 1995-1996 (95/96) the rate of SAP referral has shown a steady increase (*Table 3*). The increased services to students reflect both increased funding for services and the centrality of the program in the district's plan to address student behavioral health concerns and problems. For example, school year 1997-1998 marked the beginning of the Safe Schools/Healthy Students Initiative that supported increased SAP staff development and community

School year	1995-96	1998-99	1999-2000	2000-01
Total Referrals Grades 6-12	1,401	2,581	2,850	3,140
Enrollment Grades 6-12	18,988	19,118	19,128	19,241
Referral Rate	7.4%	13.5%	14.9%	16.3%
Base Percent Increase		+84%	+103%	+124%

TABLE 3
CHANGES IN REFERRAL PATTERNS TO THE SAP (BASE YEAR 95-96)

agency prevention and intervention services to youth.

The data collection instrument is the Pennsylvania Student Assistance Program Student Form, a 25-item instrument that collects student demographics, referral source and reason, team action, recommended services, service outcomes, and performance measures. The SAP team completes the form for each referred student who participates in the school's SAP during the school year. The Department of Education, Statewide Advisory Committee, and Commonwealth Trainers review the form annually for content validity. Furthermore, at the statewide regional SAP meetings the instrument usage and practice are reviewed and updated. To ensure the Student Performance Reporting Form reliability, as part of their SAP training team members are trained in how to complete the instrument and receive ongoing revisions and updates from regional SAP Network staff. Students are not given unique identification numbers, so it is not possible to track a student over time (e.g., year to year) or for multiple referrals.

The data analyses consisted of aggregating the annual data for each data item for each of the three years in the Pennsylvania Student Assistance Program database. The current sample of student data for the district was extracted from the larger Pennsylvania database. Descriptive statistics were then reported for each item. The students in the current study for each of the three years represent 31 secondary schools: 13 high schools (grades 9-12) and 18 middle schools (grades 6-8).

Findings

The results focus first on the students' linkages to the behavioral health care education, programs and services in the school and community. Second, school outcomes of attendance, suspensions, and grade promotion, graduation or retention after SAP participation are examined.

Behavioral Health Care System Outcomes

Students are linked through the SAP to behavioral health care education, programs and services in the school and community. Four types of behavioral health care system outcomes were examined: recommended and accessed school programs and services; recommended and accessed community programs and services; core team recommendation for an agency assessment; and agency assessment recommendations. With the current data set it was not possible to discern the number of outcomes per student.

The range of school based programs and services to which a students can be referred is expansive, and includes such options as one-to-one monitoring of student behavior (e.g. student contracts, drug testing); participation in life skill development groups such as anger management, assertiveness training, and SAMHSA model program operating in the school; work with the school counselor; and school-based individual and group mental health counseling. Consistently across all three years, 83 to 90% of the students referred were linked to a school program and service (*Table 4*), with most accessing the recommended service. Across all three years, less than 10% of all students referred to a school program or service refused to participate.



School year	1998-99	1999-2000	2000-01
SAP Referrals	2,581	2,850	3,140
School Referrals	2,164 (83%)	2,512 (88%)	2,830 (90%)
Services Accessed	1,572 (73%)	1,945 (77%)	2,252 (80%)
Some Services Accessed	440 (20%)	369 (15%)	419 (15%)
Refused Participation	152 (7%)	198 (8%)	159 (5%)

**TABLE 4
RECOMMENDED AND ACCESSED SCHOOL PROGRAMS AND SERVICES**

Students and families are referred to community programs and services. These include community based treatment programs, after-school support programs, community youth development agencies, and counseling. As part of their participation in the SAP process, about half of the students will be linked to a community program or service with more than 75% of them having some contact with the program or service (*Table 5*). However, nearly 20% of the students referred to community

programs and services refused to access them.

The third option for students is to be referred to a community agency for a behavioral health assessment (e.g., for substance abuse or depression). Across the three years, on average 60% of core team referrals resulted in a recommendation for an agency behavioral health assessment with a large percentage of students completing the assessments (*Table 6*). The assessment

School year	1998-99	1999-2000	2000-01
SAP Referrals	2,581	2,850	3,140
Community Referrals	1,556 (60%)	1,418 (49%)	1,500 (47%)
Services Accessed	939 (60%)	997 (70%)	993 (66%)
Some Services Accessed	337 (22%)	173 (12%)	226 (15%)
Refused Participation	280 (18%)	248 (18%)	281 (19%)

**TABLE 5
RECOMMENDED AND ACCESSED COMMUNITY PROGRAMS AND SERVICES**

completion ranged from 73 to 99%. A recommendation for a mental health assessment accounted for, on average almost half of the recommended assessments. Referrals to Children, Youth and Families services for domestic violence and neglect accounted for

nearly 20% of referrals. Students who presented problems related to anger management and bullying were referred to behavioral specialist at community agencies that address these issues (MH+DA, Violence).

School year	1998-99	1999-2000	2000-01
Total SAP Referrals	2,581	2,850	3,140
Recommended Agency Assessment	1,783 (70%)	1,412 (50%)	1,813 (58%)
Assessment Conducted	1,308 (73%)	1,398 (99%)	1,422 (78%)
Drug/Alcohol	150 (8%)	148 (11%)	141 (8%)
Mental Health	739 (42%)	658 (47%)	637 (35%)
MH + DA; Violence	NA	183 (13%)	180 (10%)
Children, Youth and Families	327 (18%)	297 (21%)	339 (19%)
Juvenile Probation	92 (5%)	112 (8%)	125 (7%)

**TABLE 6
CORE TEAM RECOMMENDATIONS FOR AGENCY ASSESSMENT**

Each completed agency assessment produces a recommendation. The agency assessment recommendation results revealed a mix of treatment, school support, and justice system involvement (*Table 7*). A percentage of students were not referred for further treatment or community services. Likewise a significant number (about 25%) of students did not complete the agency assessment process. The data for 99/00 comes under some suspicion with the reporting of zero for the assessment not completed

category. However, it may be due to a reporting error or instruction change for the year. The other results in *Table 7* show consistent numbers from year to year, except the assessment non-completions and the no services received categories in 99/00. Finally, it is not possible from the available data set to determine the number of individual students who completed an assessment and the number of recommendations per assessment.

School Year	1998-99	1999-2000	2000-01
Recommendations from Assessment	1,783	1,412	1,813
Drug/Alcohol Treatment—Outpatient	90 (6%)	92 (7%)	93 (5%)
Drug/Alcohol Treatment—Inpatient	17 (<1%)	16 (<1%)	13 (<1%)
Mental Health Treatment—Outpatient	586 (31%)	497 (35%)	525 (30%)
Mental Health Treatment—Inpatient	68 (4%)	61 (5%)	51 (3%)
Referral to In-school Support/Aftercare	401 (23%)	327 (26%)	362 (20%)
No Treatment or Community Services Rec'd	116 (7%)	306 (24%)	169 (9%)
Juvenile Probation	87 (5%)	113 (9%)	112 (7%)
Assessment Not Completed	418 (23%)	0 (0%)	488 (27%)

TABLE 7
AGENCY ASSESSMENT RECOMMENDATION

School Outcomes: Attendance, Discipline and Academic

Students who participate in an SAP are expected to attend school, behave, and progress academically. The specific student school outcomes examined in the current study are student attendance, suspension (for behavior or drug/alcohol policy violation), and promotion, retention and graduation status after their SAP referral. With the current data set it was not possible to discern the number of outcomes per student.

Attending school is fundamental to academic success, and a decline in attendance may be one of the first indicators that a student is experiencing a behavioral health problem. The intent of SAP partici-

pation is that student attendance will increase or at least remain stable. Likewise, often a student’s decline in attendance will stabilize before improving. The results show that approximately two-thirds of the students either improved or stabilized their attendance (**Table 8**). Likewise, a consistent one-third of the students continued to have problems with attendance after the SAP referral. When compared with the statewide percentages for attendance among SAP-referred students, students in the current sample appear to be better assisted to improve their attendance as a result of their SAP involvement.

School year	1998-99	1999-2000	2000-01
SAP Referrals	2,581	2,850	3,140
Improved	819 (31%)	952 (33%)	1,389 (44%)
No Change	907 (35%)	1,007 (35%)	858 (27%)
Declined	254 (8%)	255 (9%)	214 (7%)
Other	322 (10%)	457 (16%)	402 (13%)
Unknown	279 (9%)	184 (6%)	277 (9%)

**TABLE 8
STUDENT ATTENDANCE AFTER SAP REFERRAL**

Teams were asked to detail the reasons that students were absent from school since referral to SAP (*Table 9*). These include students who were placed on homebound instruction, dropped out, transferred, moved out of the district, or were chronically truant. The majority of students transferred out of the school or district; next in number were those who dropped out; and finally those

who were absent for other reasons including truancy. Over the three-year period there does appear to be a slight reduction in the percentages of referred students who dropped out, transferred, or were chronically absent. The number of recommendations for homebound instruction was reduced by 50%.

School Year	1998-99	1999-2000	2000-01
Other Category	322	457	402
Homebound Instruction	33 (10%)	20 (5%)	18 (5%)
Dropped Out	73 (23%)	87 (19%)	81 (20%)
Transferred—Case Closed	215 (67%)	246 (54%)	192 (48%)
Absent (Other)	0 (0%)	104 (23%)	98 (24%)
Deceased (Suicide)	0 (0%)	0 (0%)	0 (0%)
Deceased (Other)	1 (<1%)	0 (0%)	1 (<1%)
Treatment	0 (0%)	0 (0%)	12 (3%)

**TABLE 9
SAP REFERRED STUDENT DROPOUT AND ALTERNATIVE REASONS FOR ABSENCE**

The second outcome indicator examined was the suspension of referred students after SAP involvement (*Table 10*). Overall, nearly 60% of referred students incurred no further disciplinary suspensions. Data on the remaining students reveal that 20% report a suspension; and the rate of suspen-

sions for the remaining 20% is unknown. When comparing these data to the suspension data tabulated for all schools statewide, results are similar. Reasons for suspensions include behavior problems or drug/alcohol policy violations.

School year	1998-99	1999-2000	2000-01
SAP Referrals	2,581	2,850	3,140
Yes—Suspended	400 (16%)	486 (17%)	566 (18%)
No—Not Suspended	1,568 (61%)	1,723 (60%)	1,953 (62%)
Unknown	372 (14%)	641 (23%)	621 (20%)

**TABLE 10
STUDENTS SUSPENDED SINCE REFERRAL TO SAP**

The promotion, graduation and retention rates of students referred to SAP (*Table 11*) show that 63-68% of SAP-referred students either were promoted or graduated from high school. Overall, then, positive outcomes seem to occur for about two-thirds of the referred students. About 10% of

students fall into the category “Retained/Other.” Examples of outcomes for these students are repeating a grade, moving, or being placed on homebound instruction. The outcome for 25% of the referred students is unknown.

School year	1998-99	1999-2000	2000-01
SAP Referrals	2,581	2,850	3,140
Promotion	1,436 (56%)	1,534 (54%)	1,890 (60%)
Graduation	184 (7%)	307 (11%)	232 (8%)
Total	1,620 (63%)	1,841 (65%)	2,122 (68%)
Retained/Other	319 (12%)	321 (11%)	99 (3%)
Unknown	642 (25%)	688 (24%)	919 (29%)

**TABLE 11
PROMOTION, GRADUATION OR RETENTION OF SAP REFERRED STUDENTS**

Limitations

In examining these findings, we need to consider their limitations. The retrospective analysis is a research design that encounters the limits of existing state and local data.

First, students are not uniquely identified in the database. What is represented in the database is the total number of referral episodes to SAP, rather than the number of individual students who participated. If a student is referred more than once (e.g., twice in a year) he or she is counted in the database for each referral.

Second, the data consist of post-SAP measures and do not allow an adequate comparison of the change in student performance that may be attributed to involvement in SAP. For example, it is not clearly documented whether the data submitted compare a student's actual grades prior to SAP services with the student's grades subsequent to the SAP services. In some instances teams may examine school records, but in others they may have to rely on other sources such as teacher, parent, or student report.

Third, the data submitted do not clearly document how long a student is involved in SAP. In some instances, a student may have been involved in SAP from the beginning of the school year while another may have entered in April, but are treated as equals.

In spite of these limitations, a number of important conclusions, recommendations, and implications can be drawn from the study.

Discussion

SAP is a primary vehicle for schools in Pennsylvania and across the nation to address students' behavioral health needs and concerns. It identifies and links students to behavioral health care education, programs, and services in schools and communities to address learning barriers that are due to a student's social, emotional or mental health concern or problem. Consistent with national trends and increased support for Student Assistance Programs through opportunities such as Safe Schools Healthy Students Initiatives, Safe and Drug Free Schools and Communities grants, as well as local and state grants (e.g., Pennsylvania Safe Schools grant), referrals to SAPs have increased. For example, in the current study there was a 103% increase in referrals to SAP since the 1995-1996 school year. This increase in awareness and utilization of SAPs by schools and communities highlights the need for states and local communities to provide ongoing SAP training for school and community agency staff, student and family outreach, consistent technical assistance through diligent monitoring of program and team functioning, and increased programs and services from local community human services agencies.

In the current study four types of behavioral health care system outcomes were examined: recommended and accessed school programs and services; recommended and accessed community programs and services; core team recommendation for an agency assessment; and agency assessment recommendations. Students are





consistently linked to the behavioral health care system through SAP, and at a higher rate than is reported nationally (U.S. Surgeon General, 2001, Ringel & Sturm, 2001). Many students coming through a Student Assistance Program are referred to a community human services agency for an assessment. A majority of students who are linked to and assessed at the local agencies comply with the assessment recommendation and access some if not all the recommended education, programs and services.

Positive student outcomes are evident for students who participate in the Student Assistance Program. Students are expected to attend school, behave, and progress academically, so the specific school outcomes examined for students in the current study are student attendance, suspension (for behavior or drug/alcohol policy violation), and promotion, retention and graduation status after their SAP referral. Referred students show positive improvements in attendance, a decrease in discipline problems (as measured by additional suspension rate) and positive promotion and graduation status after their SAP referral.

Implications for the Student Assistance Program Field

Implications of the study for Student Assistance Program professionals focus on the student, agency assessment, and professional advocacy.

First, SAP links many—if not most—students to the behavioral health care system education, programs, and services.

While it is not possible with the current data set to track individual students, it is probably safe to surmise that the majority of participating students are linked by referral to a number of school and community behavioral health education, programs, and services as well as to an agency assessment. It is also likely that some students might only need referral to a single program or service either in the school or community. The school outcomes reveal a proportion of students whose school outcomes improved: better attendance, decreased discipline problems, grade promotion, and graduation. The most cautious interpretation of the data is that one-third of students have improved attendance, while upwards of two-thirds of students are not suspended after an SAP referral and are either promoted or graduate from school. Overall, the proportion of students having their needs met through the SAP far exceeds the nationally reported findings for youth in need of behavioral health care who for the most part do not receive them (U.S. Surgeon General, 2001, Ringel & Sturm, 2001).

Second, the Student Assistance field is in position to take actions to engage and support students who do not connect to behavioral health care system education, programs and services in school and communities, do not complete an agency assessment, and show poor school outcomes. Many of these students have probably had contact and interaction with the Student Assistance Program in their school. Student Assistance professionals working in schools and communities could be expected to take any of a number of actions to help

them. They are well situated for the ongoing identification and assessment of these students' needs and concerns, developing new programs and services, and modifying existing programs and services to better meet the needs of these students. One approach to these students is a family, school, and provider collaboration to connect these students to support and resources. These collaborations reflect an evolution in thinking about how best to serve students with serious challenges and their families. The collaborations provide the linkage between parent, community support, and school to establish continuity of care. The services are family-centered, and are designed and delivered according to the particular needs and preferences of the family members. Plans are designed to build on strengths and resources, rather than weakness and deficits. Consensus is gathered from the group to determine the needs that are in the best interests of the child. Professionals and families are seen as equal partners. Educational and behavioral goals are agreed upon. Services are comprehensive and efforts are made to ensure that the services are accessible to the family and student. The collaborations are characterized by equality, mutuality, and teamwork (Osher & Osher, 2002; Worthington, Hernandez, Friedman & Uzzell, 2001; U.S. Department of Education, 1994).

Third, student behavioral health assessment is a primary community agency responsibility. Currently most community human services agencies perform their own behavioral health student assessment protocol. A review of current

practice and literature on student behavioral health assessment, and a review of the agency's current assessment protocols will contribute to improving student outcomes. Collaborating agencies should be using valid and reliable student assessment protocols. If not, they should be encouraged to adopt a uniform, reliable and valid procedure for assessing student behavioral health. An SAP that partners with many agencies should consider an initiative establishing a common assessment protocol to be used by all collaborating agencies. This obviously requires cooperation among schools, community agencies, government human services, and professional organizations. In addition to providing information related to assessment protocols, these groups would also provide to the community agencies training and support in the use of the protocols. Furthermore, use of the protocol can be considered as a school district and community agency contract procedural item.

Fourth, individuals involved with Student Assistance Programs can do much to support their SAP. SAPs are now being implemented in many school buildings and districts to serve entire districts and communities. The National Association for Children of Alcoholics in a recent White Paper (2003) highlights the number of individuals involved with an SAP. Being involved in SAP is but one of many roles teachers, counselors, agency staff, community youth development workers, behavioral and violence prevention specialist, clergy, administrators, social workers, and nurses play in schools and communities. During the school day with its non-stop schedule





and student demands, SAP is a resource and support for teachers to help students. Problems like drug and alcohol abuse and depression present serious challenges to student learning. Various stakeholders, such as teachers, counselors, administrators, agency staff, youth workers, clergy, family members, students, and community members are all involved. They should be encouraged to know about the SAP structure and process, and how SAP fits within their school and community's approach to addressing the behavioral health of young people.

Implications for Student Assistance Program Research

The current retrospective study design uses an existing database to answer questions about Student Assistance Program outcomes. Many schools collect similar (and other) data as part of their student information records. The widespread existence and availability of such data make it a potential resource for researchers of Student Assistance Programs. Given this reality, implications of the current study for researchers of Student Assistance Programs focus on how to conceptualize Student Assistance Program research and on expanding the SAP research agenda.

First, investigate how SAP links students to the behavioral health care system. In making the argument for behavioral health education, programs, and services in schools, proponents focus on the gap between child and adolescent behavioral

health needs, and their actual utilization of behavioral education, programs, and services. And, although reported statistics vary, it is generally agreed that as many as 80% of youth in need of behavioral health services may not receive them (U.S. Surgeon General, 2001; Ringel & Sturm, 2001). SAP directly addresses this chasm between students and the behavioral health care system. Using the existing data sources to explore how SAP builds bridges and makes connections is critical to linking students with the resources they need, as well as developing new resources to meet unmet needs. SAP contributes to student academic success and achievement. However, the four-phase SAP process (Fertman et al, 2001) that is employed across SAP models (e.g., school team based or externally based) is primarily concerned with making the connections. SAP researchers need to use the data to make the case for SAP conceptualized as a bridge between and among systems. For example, recent research on the use and extent of available referral options (Fertman & Ross, 2003) highlights the intricacy of linking students to education, programs and services, especially when those options include the family and self-help groups in the community.

Second, develop and implement performance measures that demonstrate and delineate the intent and purpose of Student Assistance Programs. It is clear from the SAP research that SAP has certain qualities that enable it to fit the SAMHSA rubric and that such recognition is desirable. However, SAP can be thought of as more

than a program. In re-conceptualizing SAP as a process of bridging systems, the challenge for researchers is to use the existing data sources to promote the idea of SAP as a bridge and to design studies that support it. Furthermore, as part of that idea, thought needs to be given to a set of performance measures consistent with the Student Assistance Program objectives to be collected and analyzed across settings, location, and model. The performance measure would need to be consistent with and complementary to the GPRA (Government Performance and Results Act) measures of both the U.S. Departments of Education and Health and Human Services while clearly demonstrating and delineating the intent and purpose of Student Assistance Programs. The federal No Child Left Behind Act of 2002 (NCLB) contains several guidelines that are relevant to SAP and also need to be considered as part of any performance measure development and implementation. The Office of Adolescent Health, Maternal and Child Health Bureau national centers for school mental health located at the University of Maryland and UCLA can also aid in this process. The National Association of Student Assistance Professionals working with the U.S. Department of Education, Office of Drug Free Schools, U. S. Department of Health and Human Services, Center for Substance Abuse Prevention; and the White House Office of National Drug Control Policy can lead the development and implementation of the performance measures.

Third, focus research on Student Assistance Program implementation.

Despite growing literature documenting prevention and health promotion interventions that have proven successful in well-controlled research, few of these interventions are consistently implemented in applied settings (Glasgow, Lichtenstein & Marcus, 2003; Ringwalt, Ennett, Johnson, Rohrbach, Simon-Rudolph, Vincus & Thorne, 2003; Simons-Rudolph, Ennett, Ringwalt, Rohrbach, Vincus & Johnson, 2003). This is true across preventive counseling services for numerous target behaviors, including tobacco use, dietary change, physical activities and behavioral health (e.g., alcohol use, depression). Several recent review and meta-analyses have documented this gap (Clark, 1995; Weisz, Weisz & Donnenberg, 1992; Smedley & Syme, 2001). To close this gap, there must be substantially more demonstrations of how to implement programs and services effectively in typical settings and in locations serving minority, low-income, and rural populations facing health disparities. Student Assistance Program researchers as well as the National Association of Student Assistance Professionals, can use state and local data to help close the gap between research and practice. ■



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APPENDIX

PENNSYLVANIA STUDENT ASSISTANCE STUDENT INFORMATION FORM

2001-2002 SCHOOL YEAR PA STUDENT ASSISTANCE PROGRAM

For your records only!
Do not submit data on this form.

Data must be submitted online at
www.sap.state.pa.us.

STUDENT NAME _____
STUDENT ID _____
REFERRAL DATE _____

NOTES

1. CASE NO. _____
2. STUDENT AGE _____
3. GRADE LEVEL _____
4. SEX Female Male
5. SPECIAL EDUCATION Yes No
6. GIFTED Yes No

7. RACE
 White
 Black
 American Indian/
 Eskimo/Aleut
 Pacific Islander
 Asian
 Other Race
 Unknown

8. IS THIS STUDENT OF HISPANIC/LATINO ORIGIN?
 Yes
 No

10. INCOMING REFERRAL REASON (MARK ALL THAT APPLY)

- Violated school policy, D&A related
- Violated school policy, violence/weapons
- Violated school policy, other
- Behavioral concerns
- Performing below academic ability
- Unexplained drop in grades
- Attendance
- Continuation of case from another SAP team
- Suicide ideation, gesture or attempt
- Re-entry into school
- Self-reported problem
- Other

11. IF STUDENT WAS REFERRED TO SAP IN PREVIOUS GRADE(S): (MARK ALL THAT APPLY)

<input type="radio"/> K	<input type="radio"/> 3	<input type="radio"/> 6	<input type="radio"/> 9	<input type="radio"/> 12
<input type="radio"/> 1	<input type="radio"/> 4	<input type="radio"/> 7	<input type="radio"/> 10	
<input type="radio"/> 2	<input type="radio"/> 5	<input type="radio"/> 8	<input type="radio"/> 11	

12. PARENT/GUARDIAN INVOLVEMENT (ANSWER ALL QUESTIONS)

Yes No

- Parent/guardian contact initiated
- Parent/guardian contact completed
- Parent/guardian approval for SAP process
- Parent/guardian participation in SAP process

13. IF SAP PROCESS DISCONTINUED, INDICATE REASON (MARK ALL THAT APPLY)

- Student refusal
- Parent refusal
- SAP process not warranted
- Other

9. INCOMING REFERRAL SOURCE (MARK ALL THAT APPLY)

- Team Member
- Teacher
- Counselor
- Nurse
- Disciplinary
- Administrative, Non-Disciplinary
- School Psychologist
- Social Worker
- Transfer From Another School
- Pre-school/Head Start
- Early Intervention
- Legal System (JPO, court, police, etc.)
- Instructional Support
- Self
- Parent/Guardian
- Peer
- Community Agency
- Other

**IF YOU INDICATED A RESPONSE TO #13, STOP HERE.
DO NOT COMPLETE REMAINDER OF FORM.**

14. [A] SCHOOL SERVICES RECOMMENDED BY CORE TEAM (MARK ALL THAT APPLY)

- One-to-one counseling with guidance counselor, school psychologist, etc.
- One-to-one follow-up with team member or other school personnel
- Multidisciplinary Team Evaluation (MTE)
- Services by/from school social worker
- Mental health special issues group (divorce, grief and loss, etc.)
- Mental health aftercare/support group
- Drug and alcohol education/prevention group
- Drug and alcohol aftercare/support group
- Other in-school group
- School-based juvenile probation
- Team intervention
- Crisis intervention
- Alternative school placement
- Academic supports
- Teen parenting/pregnancy program
- Drop-out prevention program
- Mentoring
- Other

14. [B] WERE RECOMMENDED SCHOOL SERVICES ACCESSED?

- Yes
 - Some
 - No
- IF NO OR SOME, INDICATE WHY (MARK ALL THAT APPLY)**
- Services unavailable
 - Pending or incomplete
 - Transportation problems
 - School scheduling
 - Student refused
 - Other
 - Parent/guardian refused
 - Don't know
 - Waiting list

15. [A] COMMUNITY/AGENCY SERVICES RECOMMENDED BY CORE TEAM (MARK ALL THAT APPLY)

- Assessment by licensed drug and alcohol provider
- Assessment by licensed mental health provider
- Assessment by behavior specialist (e.g. combined D&A, MH, violence, etc.)
- Other social services agencies (e.g. Children, Youth & Families Services)
- Juvenile probation
- Other

15. [B] RECOMMENDATIONS FROM ASSESSMENT (MARK ALL THAT APPLY)

- Drug/Alcohol treatment - Outpatient
- Other community services
- Drug/Alcohol treatment - Inpatient
- No treatment or other community services recommended
- Mental Health treatment - Outpatient
- Juvenile probation
- Mental Health treatment - Inpatient
- Information not available
- Mental Health treatment - Behavioral health rehab services
- Referral to in-school support/aftercare services

15. [C] WERE RECOMMENDED COMMUNITY/AGENCY SERVICES ACCESSED?

- Yes
 - Some
 - No
- IF NO OR SOME, INDICATE WHY (MARK ALL THAT APPLY)**
- Services unavailable
 - Student refused
 - Transportation problems
 - Parent/guardian refused
 - Cost prohibitive
 - Waiting list
 - No insurance
 - Pending or incomplete
 - Insurer refused to approve level of care recommended
 - Other
 - Don't know

16. IF STUDENT IS NOT ATTENDING SCHOOL, INDICATE WHY (MARK ANY THAT APPLY)

- Student receiving homebound instruction
- Student deceased - suicide
- Student dropped out
- Student deceased - other
- Student transferred - case closed
- Inpatient treatment
- Student absent - other
- Juvenile Detention Facility
- Alternative Education

**IF YOU INDICATED A RESPONSE TO #16, STOP HERE.
DO NOT COMPLETE THE FOLLOWING PERFORMANCE MEASURES.**

PERFORMANCE MEASURES

17. THIS STUDENT'S ATTENDANCE HAS

- Improved
- Remained the same
- Declined

18. THIS STUDENT'S OVERALL ACADEMIC PERFORMANCE HAS

- Improved
- Remained the same
- Declined

19. THIS STUDENT WAS SUSPENDED SINCE CURRENT REFERRAL.

- Yes
- No

20. THIS STUDENT VIOLATED D&A POLICY SINCE CURRENT REFERRAL.

- Yes
- No

21. THIS STUDENT WAS (MARK ONLY ONE)

- Promoted
- Graduated
- Retained
- Other