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Behavioral Health Student Assistance Programs: Leveraging Non-Traditional Mental Health Providers to Address Workforce Shortages and Mitigate the Youth Mental Health Crisis

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Abstract

Workforce shortages and other barriers have undermined efforts to address recent spikes in youth behavioral health problems. This study evaluates Washington State's Behavioral Health Student Assistance Program (BH-SAP), a novel approach to addressing the youth behavioral health crisis by using paraprofessional-delivered services in schools to expand the continuum of services available to youth. During the 2022-23 school year, 60 Student Assistance Specialists (SASs) delivered 3,218 prevention activities, provided group interventions to 1,158 students, and served 2,532 students with individual interventions, though there was substantial variation in the relative rates of BH-SAP activities across Washington's nine regional Educational Service Districts. Students receiving group and individual interventions reported significant improvements in hope, social connection, mental health agency, and reductions in internalizing symptoms and behavioral incidents, with small to moderate effect sizes (d = 0.23–0.39). Over 96% of N = 1,061 students who completed surveys reported the program was helpful. Students served by SASs who demonstrated greater adherence to the state's BH-SAP fidelity rubric showed greater improvements than those from lower-adherence providers. Results show that paraprofessionals, when properly trained and supervised, can effectively expand the workforce and extend the reach of evidence-based interventions in schools, and that a consistently implemented student assistance program can provide a promising strategy to address the youth mental health crisis.

Introduction

Since 2010, rates of depression, anxiety, and suicidality in children and adolescents have risen to historic highs (Ivey-Stephenson et al., 2020), with rates spiking further during the COVID-19 pandemic (Yard et al., 2021; Hill et al., 2021; Leeb et al., 2020). Despite this growing crisis, studies consistently demonstrate that fewer than half of children and adolescents in need of behavioral health support receive any treatment (Whitney & Peterson, 2019). The behavioral health workforce has not expanded to meet this unprecedented demand, leading to significant gaps in service delivery and access to care (National Center for Health Workforce Analysis, 2024).

Schools are the most common setting for mental health service delivery for children and youth in the United States (Duong et al., 2021). This evolution is logical, as schools represent a low-barrier access point for preventing, identifying, and addressing substance use and mental health concerns early in their trajectory (Kataoka et al., 2007; Lyon et al., 2013). Studies consistently show that school-based behavioral health services improve treatment completion rates, with youth receiving services in schools being many times more likely to complete treatment

compared to community settings (Jaycox et al., 2010). This improved engagement can be attributed to reduced barriers such as transportation challenges, scheduling conflicts, and stigma associated with seeking mental health care.

However, school systems remain limited by resource and workforce shortages that restrict the effectiveness of their programming (García & Weiss, 2019; Graves et al., 2023). School-employed professionals operate at ratios far exceeding recommended guidelines, as illustrated by school psychologist-to-student ratios exceeding the National Association of School Psychologists' recommended 500:1 in all but one state during the 2021-2022 school year (NASP, 2020). Similar concerning trends exist for school counselors and social workers. While partnerships with community-based providers have helped address some gaps, these professionals typically focus on students with the most acute needs, leaving limited capacity for broader mental health promotion and prevention efforts (Reaves et al., 2022).

These challenges in the education workforce create significant barriers to implementing the full continuum of services recommended by the Multi-Tiered System of Supports (MTSS) framework. MTSS in schools ideally comprises three tiers: Tier 1 universal prevention and promotion efforts supporting all students through school-wide strategies such as social-emotional learning programs and positive behavior supports; Tier 2 targeted interventions for at-risk students through mentorship, skills-based groups, and brief interventions; and Tier 3 intensive, individualized supports for students with identified mental health concerns (Eklund et al., 2020; Center for School Mental Health, 2018).

While this framework is designed to improve students' social, emotional, behavioral, and academic functioning, schools struggle to achieve the full continuum of care. Among other challenges, staffing limitations constrain schools’ ability to conduct Tier 1 and 2 activities such as prevention programming and early intervention, despite these strategies’ goal to prevent substance use and mental health problems from worsening and interfering with students’ learning.

Paraprofessionals and Task Shifting

Two promising strategies for addressing these workforce challenges in school behavioral health are the use of paraprofessionals and task shifting. Task shifting, as defined by the World Health Organization (2008), is "a process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications" (p. 7). Paraprofessionals are trained workers who support and extend the work of professionals but do not hold advanced degrees in the field. In both health and behavioral health settings, these approaches have been recognized for yielding more efficient distribution of resources and services while maintaining quality of care (WHO, 2008; Zachariah et al., 2009).

Use of paraprofessionals is particularly well-suited to educational settings, where task shifting is already nearly ubiquitous through roles such as teacher aides or assistants providing academic remediation or behavioral support (Page & Ferrett, 2018). With respect to school behavioral health, evidence is emerging that demonstrates the effectiveness of paraprofessional-delivered interventions across multiple domains. Studies have shown that paraprofessionals can successfully implement Motivational Interviewing in schools to address externalizing behaviors (Hart et al., 2023), deliver academic motivation-building interventions with outcomes comparable to professional providers (Strait et al., 2020), and conduct semi-structured interventions like the Student Check-Up that improve academic attitudes, commitment, effort, and self-efficacy (Strait et al., 2017).
Research suggests that paraprofessional-delivered supports could complement and expand services across all MTSS levels by facilitating access to evidence-based interventions, enabling skills application and practice, and delivering treatments (Hart et al., 2021; McQuillin et al., 2021). This approach not only benefits youth but also relieves other

providers of certain responsibilities, improving access to individualized and intensive services while also providing initial rungs on the career ladder, thus growing the behavioral health workforce.

Behavioral Health Student Assistance Programs

Behavioral Health Student Assistance Programs (BH-SAP) are one method for shifting from specialized and professionalized behavioral health to a more scalable and comprehensive paradigm. Originally designed to mirror employee assistance programs to support worker wellbeing (with elements such as confidential assessments, short-term counseling, and referrals), BH-SAP can provide comprehensive and accessible help for youth across the tiers of behavioral health by providing supports embedded within their everyday education experience.

A key feature of some BH-SAP is the use of paraprofessionals with associate and bachelor's degrees called, variously, Student Assistance Professionals, Partners, or Specialists (hereafter referred to as Student Assistance Specialists, or SAS). SAS support and enhance the work of school staff by conducting activities that neither school staff nor Master's level behavioral health practitioners typically have time for, such as school-wide substance abuse education, mental health stigma reduction, and other school-wide prevention activities. At the same time, SAS can provide group- and individual-level interventions to students in a way that reduces reliance on highly trained, credentialled specialists such as Masters-level behavioral health clinicians, freeing these staff up for more intensive and specialized interventions.

BH-SAPs have a long history of implementation in U.S. schools, with programs in Vermont, Pennsylvania, Illinois, and Washington highlighted in federal reports presenting basic descriptions of the BH-SAP model (SAMHSA, 2019). In addition, a small number of peer-reviewed papers (Wagner et al., 1999) and evaluation reports from states such as Pennsylvania (Fertman et al., 2003) have reported positive outcomes of BH-SAPs.

However, most evaluations focused on students' satisfaction with the program and/or relied on students' retrospective self-report of outcomes. There also is wide variation in BH-SAP programming in the small number of published reports. For example, the SAP programming evaluated by Wagner et al. (1999) consisted solely of a 10-session group intervention for "Abusers" provided in Rhode Island schools focused on substance abuse education and refusal skills. The SAP model in Pennsylvania evaluated by Fertman et al. (2003) did not include direct intervention, but rather consisted of teams of school staff working together to identify issues and refer students to services, delivered by outside community agencies. Neither of these evaluations focused on programs that included interventionists such as SASs.

The Current Study

The current paper aims to contribute to the literature on both BH-SAPs as well as the youth behavioral health workforce by providing the first description and evaluation of a school-based BH-SAP that incorporates paraprofessional practitioners. First, the paper will present details on the statewide BH-SAP in Washington State, including its practice model and fidelity parameters. The paper will then present results from an evaluation of the Washington BH-SAP, including activity data from a state-wide web-based session log and activity database, BH-SAP model adherence data from the activity log and regional coordinator surveys, and student outcomes from surveys comprising several standardized measures, administered before and after receipt of BH-SAP interventions. Specific research questions include:

1. What activities did BH-SAP conduct across Tier 1 (prevention and community outreach) and Tier 2 (group and individual interventions) and how much did these activities vary across Washington's nine regional Educational Service Districts?
2. What level of adherence to the statewide BH-SAP fidelity model was achieved overall and by region?

3. What changes in behavior, emotions, substance use, and school outcomes were reported by students from pre- to post-BH-SAP intervention overall and for those served by SASs with high and low fidelity?
4. How well-perceived was the BH-SAP by students who received intervention services?

Method

Study Setting

The current study presents data from 60 SASs serving 88 school buildings (12 elementary, 30 middle, and 41 high schools; 5 K-12 schools) in 52 districts in Washington State during the 2022-23 school year. BH-SAP expanded statewide in Washington during the COVID-19 pandemic in response to the increase in student behavioral health needs using federal COVID relief funds. To maintain a consistent practice model, the Washington Association of Educational Service Districts (AESD) oversaw a process of disseminating resources to the state's nine ESDs based on the number of students in high-need schools in each ESD. As shown in Table 1, the number of districts in each regional ESD with SASs via BH-SAP in 2022-23 ranged from 4-10 (mean = 5.8) and the number of schools in each ESD with a BH-SAP ranged from 5-17 (mean = 9.8). Only 3.5% of all Washington public schools had a BH-SAP that included an SAS as a part of the program.

Table 1. Number of Districts and Schools with BH-SAP in 2022-23, by Educational Service District (ESD)

ESD	1	2	3	4	5	6	7	8	9	Total
Districts with BH-SAP	8	4	10	5	4	6	4	6	5	52
Schools with BH-SAP	17	8	17	5	6	8	6	13	8	88
Total Districts	59	25	30	44	15	35	23	29	35	295
Total Schools	296	156	225	202	111	812	173	147	374	2,496
% BH-SAP Districts	13.6%	16.0%	33.3%	11.4%	26.7%	17.1%	17.4%	20.7%	14.3%	17.6%
% BH-SAP Schools	5.7%	5.1%	7.6%	2.5%	5.4%	1.0%	3.5%	8.8%	2.1%	3.5%

Note. BH-SAP = Behavioral Health Student Assistance Program

Participants

BH-SAP services were provided in 88 school buildings, including 5 elementary schools, 5 K-12 schools, 42 middle schools, 28 high schools, and 8 alternative schools. Students in these schools were 54% White (compared to 49.5% for all students in Washington State). 30% of students in these schools were of Hispanic/Latino ethnicity (of any race). Over half (56%) of student households met the criteria for low income (eligible to receive free or reduced-price meals).

At schools participating in the BH-SAP program, students are referred to SASs by school administrators, teachers, school teams, other staff members, family members, or the student themselves. SASs then complete initial screening to determine if a referred student could benefit from SAS-provided intervention services (individual, family, or group-based) or additional referral to other providers (within the school or local community). The screening intake session typically takes an hour and uses the Global Appraisal of Individual Needs-Short Screener (Dennis, 2006) to assess whether a student may have internalizing, externalizing, substance use disorders, and crime or violence problems. If the student is 10 or younger, the screening takes place with the parent/caregiver rather than the student. If the student is 11 or 12 the screening may take place with the student or the parent/caregiver depending on the circumstances.

Table 2 provides demographic information for the 2,532 students receiving SAS intervention services in 2022-23. Of these students, the majority were identified through non-discipline referrals (82%) and were in grades 9–12 (51%). Individual/group interventions were provided primarily to students who were non-Hispanic White (56%) and identified as female (55%).

Table 2. Demographics of 2,532 Students Receiving BH-SAP Intervention Services

Demographic Characteristic	N	%
Referral Type		
Non-Discipline	2,075	82.0%
Discipline	449	17.7%
Missing	8	0.3%
Grade Level		
9-12	1,299	51.3%
6-8	1,079	42.6%
K-5	146	5.8%
Missing	8	0.3%
Race/Ethnicity		
Asian	47	1.9%
Black non-Hispanic	152	6.0%
Hispanic	519	20.5%
multi-ethnic	212	8.4%
Native American	83	3.3%
Pacific Islander	29	1.1%
White non-Hispanic	1,413	55.8%
Missing	77	3.0%
Gender		
Female	1,375	54.3%
Transgender Female	13	0.5%
Male	993	39.2%
Transgender Male	51	2.0%
Non-binary	95	3.8%
Other	5	0.2%

Intervention: Washington's Behavioral Health Student Assistance Program

Washington's BH-SAP was designed to emulate a national framework and practice model promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2019). It builds on a structure of regional and statewide support to ensure program alignment and efficacy.

Each SAS supports and expands the capacity of their school's multi-tiered, stepped care framework (Stephan et al., 2015) enhancing the school's behavioral health supports and helping the school meet the needs of all students.

BH-SAP Key Personnel

Washington's BH-SAP model identifies three distinct categories of key personnel. Each of these roles has responsibilities within the program.

State Lead and External Evaluation. Together, the State Lead and External Evaluator provide program leadership and oversight, stakeholder engagement, data monitoring, and program evaluation to promote a consistent, sustainable state-wide program.

Regional Behavioral Health Coordinators. Each of the state's nine ESDs employs a full-time Regional Behavioral Health Coordinator, responsible for local implementation and oversight of BH-SAP as well as hiring, training, and supervision of regional SASs. This position requires a minimum of a bachelor's degree and at least five years of experience coordinating behavioral health or student support programming. In addition to local program implementation and supervision, Regional Coordinators play a pivotal role in continuous program improvement. All nine Regional Coordinators meet as a team with the State Lead and Evaluator every other week to provide local updates, monitor data quality, discuss potential program updates, and receive technical assistance.

Student Assistance Specialists. Each SAS position serves a minimum of 180 days at a designated school site. While the SAS is an employee of an ESD and supervised by a Regional Coordinator, most of their time is spent embedded within their assigned school. The position requires an associate's degree or higher and at least two years of experience working with youth in school or community settings. As a paraprofessional role, no credentialing or licensing is required. Once hired, SASs receive training on topics including program requirements, data collection, Motivational Interviewing, confidentiality, group engagement, and the specific Tier 1 and Tier 2 curricula they will deliver. Each SAS is supervised by a Regional Coordinator and meets regularly with both their Coordinator and the other SASs in their ESD.

BH-SAP Practice Model

Within the BH-SAP practice model, SASs provide school-based behavioral health supports aligned with each level of a multi-tiered system of support.

Tier 1 Universal Supports.

SASs provide school-wide support intended to reach all students via mental health education and substance use prevention activities. Tier 1 activities include awareness campaigns, classroom presentations, and information dissemination with the goal of raising awareness and reducing the stigma around behavioral health. As part of the Tier 1 supports, SASs facilitate youth leadership clubs whose members help prepare and run the universal awareness campaigns including suicide prevention, bullying prevention, substance use prevention and mental wellness promotion. In addition to the student-focused activities, BH-SAP also provides education and promotion to school staff, families, and the community through activities such as awareness presentations, newsletters, and trainings. Parent and community activities are often offered in partnership with other local family or community-focused partners.

Tier 1 BH-SAP activities include support to screening, early identification, and triage. Universal behavioral health screening is required by state statute; however, policies and procedures in Washington vary greatly, from universal screening using well-established measures completed by students, to universal screening using teacher identification, to no formal method for screening and reliance on teacher and student self-referral (University of Washington, 2024). Thus, SAS support to this process is fit to local building and district context. Once students are identified, students may be connected to services and supports via the school's existing MTSS team, of which the SAS is an integral member. Within the MTSS team, SASs provide content knowledge, make and receive referrals, help identify additional supports for students, and share updates as appropriate.

Tier 2 Targeted Strategies.

At Tier 2, SASs conduct follow-on screening using standardized measures, provide evidence-based group and individual early interventions, and refer out to additional services and supports as appropriate. When students are identified via referral, SASs screen 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, & Bedoya, 2006; see also Dennis, Chan, & Funk, 2006). The GAIN-SS consists of four, 5-6 item subscales that assess

whether a student may have internalizing disorders, externalizing disorders, substance use disorders, and crime or violence problems. This brief instrument was developed to identify youth in need of formal treatment; for example, a score of 1 or 2 suggests a possible diagnosis and indicates that the student would likely benefit from a brief intervention in the school setting. A score of 3 or more suggests a high probability of a diagnosis and indicates that a formal assessment and treatment are appropriate.

For students appropriate for early intervention, SASs are trained and supported to use a range of evidence-based group and individual interventions. For example, all SASs are trained to use TRAILS (Transforming Research into Action to Improve the Lives of Students), a cognitive behavioral therapy (CBT)-based individual or group intervention that teaches effective strategies to manage common symptoms of depression and anxiety, such as feelings of hopelessness, decreased energy, worried thoughts, and avoidant behaviors (Rodriguez-Quintana et al., 2021). TRAILS modules include skills that can be taught by paraprofessionals, such as mindfulness and relaxation and behavioral activation.

With respect to substance use, SASs also receive training and consultation on substance use interventions such as *Teen Intervene,* a brief intervention administered in two to three one-hour long sessions with the teen and their family focused on positive behavior change and harm reduction (Winters, 2023). All SASs are also trained in Motivational Interviewing (Rollnick & Miller, 1995) and use it to support successful provision of all student interventions.

Tier 3 Intensive Services.

For students in need of Tier 3 services, BH-SAP provides a mechanism for referral to treatment and ongoing care coordination with both in-school and external support. By focusing on prevention and early intervention services while referring out to a licensed provider who can bill public managed care or private insurance, Washington's BH-SAP aims to maximize the return on investment of state general fund dollars to the program while exploring alternative payment methodologies to cover these critical services.

BH-SAP Fidelity Framework

Implementation fidelity is the degree to which all elements of an intervention were implemented as intended and has been shown to be related to effectiveness of school-based programs (Durlak & DuPre, 2008; Jensen et al., 2024; Rojas-Andrade & Bahamondes, 2019). To define adherence criteria for this program, the Washington BH-SAP fidelity rubric (Table 3) was created. This rubric consists of 10 indicators, each of which represents a program component expected of the SAS. These indicators/components are organized by three categories: Universal Prevention Activities (six components), Group-Based Early Intervention Activities (one component), and Individual Student Intervention (three components). As shown in Table 3, these components reinforce the expectation that SASs should participate in different types of school teams, provide school-wide activities such as classroom education and universal prevention programs, provide group-based early intervention programs (including specific evidence-based curricula), and intervene individually with students via screening, Tier 2 treatment, and referral to Tier 3 services when needed.

Table 3. Behavioral Health Student Assistance Program (BH-SAP) Fidelity Indicators and Rate of Adherence by 60 Student Assistance Specialists (SAS)

	Activities Completed			Adherence Rate
Program Component	**Mean (SD)**	**Range**	**Fidelity Indicator(s)**	**N (%)**
Universal Prevention Activities (Sessions)				
Participate in school building staff meetings	1.8 (2.250)	0-8	Attend at least 3 staff meetings per school	18 (30%)
Provide classroom presentations on:			At least 1 MH and 1 SU presentation per year	13 (22%)
Mental health (MH)	2.4 (6.0)	0-30		
Substance use (SU)	1.0 (3.3)	0-25		
Coordinate and implement universal MH and SU prevention campaigns	3.5 (8.7)	0-68	At least 4 awareness activities per year	17 (28%)
Participate in multidisciplinary team meetings to facilitate and coordinate referrals and supports	6.0 (14.9)	0-109	Staff participated in a minimum of 3 multidisciplinary team meetings per school	17 (28%)
Facilitate or partner with Youth Prevention Club and coordinate activities for the school community	2.4 (6.8)	0-38	Staff recorded a minimum of 3 Youth Prevention/Leadership club meetings per school	10 (17%)
Lead or participate in parent and/or community MH / SU training	0.4 (1.2)	0-8	Staff recorded a minimum of 2 parent and/or community trainings	6 (10%)
Group-Based Student Interventions (Groups Convened)				
Implement group-based intervention curricula	1.3 (2.3)	0-12	Staff conducted at least 1 TRAILS group	29 (48%)
Individual Student Intervention (Students Served)				
Conduct MH/SU screening using standardized measure	33.2 (27.5)	1-127	100% of students were screened	24 (40%)
Provide individual interventions to students	28.9 (18.4)	1-86	100% of students received at least 1 intervention service	32 (53%)
Refer students to more intensive services as needed	14.7 (18.0)	0-77	100% of students received at least 1 referral	6 (10%)

The fidelity framework is intended to serve several purposes. The framework is used to orient SASs to their role and help structure oversight and supervision by BH-SAP coordinators at the nine ESDs that employ them and oversee their work in schools. The fidelity rubric also serves as a foundation for orientations and trainings on the universal Tier 1 and targeted Tier 2 activities described above. The framework is also used to organize data from SAS activity logs, and feed data back to ESDs summarizing their fidelity to the model.

Measures

BH-SAP Activities

SASs use an online database to enter information on their activities daily or, at a minimum, weekly. The online database includes categories of activity types (e.g., Community Event, Classroom Presentation, Prevention Program) and target audience (e.g., Student, Family, School Staff). SASs also record information such as the activity date, school, number of participants, duration, and a brief description.

Fidelity

For this study, a BH-SAP adherence score was calculated for each SAS based on the BH-SAP fidelity rubric (Table 3). Using the SAS activity log data, the external program evaluator assigned a score of 0 (not achieved) or 1 (achieved) to the SAS for each of the 10 adherence indicators. For example, if a SAS logged at least three staff meetings per school, the SAS would receive a score of 1 for the first program fidelity component ("participate in school building staff meetings"). A total fidelity score was then calculated by summing the number of indicators each SAS achieved out of 10 total, resulting in a score of 0–1 (or 0-100%). For example, if a SAS had 5 indicators in place, they would have a score of 0.5 (50%).

To categorize high vs. low fidelity, a median-split cut-point was established based on the distribution of SAS fidelity scores. The median SAS fidelity score for SASs in the study was.4 (or 40%); thus the "low fidelity" group consisted of SASs that achieved an adherence score of < 0.4 and the high-fidelity group was defined as 0.4 or higher. To compare outcomes for high and low fidelity groups, each student receiving intervention services was then assigned to a fidelity group ("high" or "low" fidelity) based on score achieved by the SAS that served the student.

Student Outcomes

The primary measure of BH-SAP impact is a 30-item student self-report survey designed to assess emotional well-being, behavioral health symptoms and functioning, school engagement and connectedness, and satisfaction with BH-SAP services received. The survey was developed by the program evaluators and the statewide lead in July 2022 and piloted with regional coordinators to ensure adequate face validity. To assure feasibility and reduce participant burden, the survey combines selected items from several standardized measures.

Four items were drawn from the Children's Hope Scale (CHS; Snyder et al., 1997) to represent children's beliefs in their capacity, self-efficacy, and motivation to reach their goals. The four-item version used in this study was found to be by valid by the administrators of the Washington Healthy Youth Survey (Washington State Office of the Superintendent of Public Instruction (OSPI), 2021). Three items were derived from the Student Engagement in Schools Questionnaire (SESQ; Hart et al., 2011) to represent Behavioral and Affective Learning. Two items were adapted from the Social Emotional Health Survey (SEHS; Furlong et al., 2014) to represent students' connectedness with peers and adults in the school setting. Two items were drawn from the Brief Problem Checklist (BPC, Chorpita et al., 2010) to capture students' depression symptoms. One item was selected from the Generalized Anxiety Disorder 7-item scale to measure anxiety symptoms (GAD-7, Spitzer et al., 2006). Additionally, two items addressing mental health agency were developed by the evaluation team ("I know how to ask for help when I need it" and "When I experience negative emotions, I have healthy strategies to calm myself down").

Response options for the novel items as well as those derived from the CHS, SESQ, SEHS, BPC, and GAD-7 all used the same 6-point scale, ranging from 0 ("none of the time") to 5 ("all of the time"). The pre-post survey also incorporated a set of questions used in a similar statewide effort, the Student Assistance Prevention and Intervention Services Program (OSPI, 2023). This included six items assessing frequency of risk behaviors (e.g., physical fighting, school suspensions) and seven items assessing frequency of substance use (e.g., alcohol use, marijuana use, cigarette smoking) measured during the past 30 days and using a 5-point scale (None, 1-3 Days, 4-12 Days, 13 or More Days, and Every Day).

All items, except the two capturing mental health agency developed for the current study, were derived from previously validated and reliable scales that have been used in school settings to assess program outcomes with similar populations (Hellman et al., 2018; You et al., 2014; Mossman et al., 2017). For the purposes of this paper, individual items were retained for the analyses; no composites were created to represent constructs. The full student Pre/Post measure is available as an online supplement to the current paper.

Satisfaction with BH-SAP Services

For the post-test only, the student self-report survey incorporates three items assessing the student's satisfaction with the services they received which have been used in a similar statewide effort, the Student Assistance Prevention and Intervention Services Program (OSPI, 2023). Students rate how helpful they have found the program (Very Helpful, Somewhat Helpful, Not Very Helpful, Not at All Helpful) and whether they are glad they participated in the program (YES! - definitely true, yes - Mostly true, no- Mostly not true, NO! - definitely not true). Additionally, students indicate whether they were more likely to attend school because of the program (Yes, No, Does not apply to me; I attend school regularly).

Data Collection

SASs entered data on activities and student demographics and outcomes using a secure, web-based online database maintained by Looking Glass Analytics (LGAN). When students are enrolled to group or individual interventions, student demographic information and behavioral health screening with the GAIN-SS are entered into LGAN.

Students in Grades 6–12 complete the program's Pre/Post Survey (described above) before initiating an intervention and again at the end of services. For the current study, the mean duration between baseline and follow-up surveys was found to be 112 days. Student surveys were administered by the SAS via scantron or computer and completed confidentially, without sharing results with the SAS. Results for all students were compiled in the LGAN data system and available for SASs and coordinators to review by school for purposes of continuous quality improvement.

Data Analysis

For RQ1 and RQ2 (describing SAS activities and fidelity scores), frequency distributions were created to summarize the distribution of item-level scores across the full statewide sample, and by ESD. Where applicable, mean, range, and standard deviations were also calculated to measure central tendency and variability. For RQ3 (exploring student behavioral outcomes), paired sample t-tests were used to evaluate significance of changes in item-level means from pre- to post-test, for three groups (overall, students who were served by SASs with high fidelity, and students served by SASs with low fidelity). Differences with a $p < 0.05$ were considered significant differences. We also calculated effect sizes using Cohen's *d,* and interpreted effect sizes using conventions proposed by Cohen (1988). Analyses were conducted with IBM SPSS Statistics 29. Finally, for RQ4, frequency distributions were used to examine student satisfaction scores.

Results

Research Question 1: BH-SAP Activities and Variability Across ESDs

Prevention Activities

Table 4 presents the number and types of universal prevention service sessions delivered via Washington's BH-SAP. As shown, during 2022-23, the state's 60 SASs reported delivering a total 3,218 prevention sessions. Planning activities such as screening and referral services within a multidisciplinary team, coordinating with community coalitions or advisory groups, and planning for universal prevention activities were most common, followed closely by mental health and substance use awareness programming, such as program outreach, information dissemination, and awareness campaigns.

Table 4. Mean and Total Number of Universal Prevention Service Sessions delivered by Student Assistance Specialists, by Type

Activity Type	Mean (SD) by ESD	Range by ESD	State Total
Awareness	133.78 (79.79)	16 - 252	1,204
Curriculum	35.63 (29.69)	2 - 94	285
Education	21.56 (14.25)	3 - 45	194
Peer	22.00 (19.92)	1 - 60	198
Planning	148.56 (76.40)	61 - 305	1,337
All Prevention	357.56 (161.08)	142 - 622	3,218

Delivery of formal prevention curricula (e.g., Project Alert, Second Step, Life Skills) were provided far less frequently than awareness or planning activities, as were education activities (e.g., Prevention Education Series, Newcomers Group, Stress Anxiety and Coping Skills Presentations) and peer activities (behavioral health leadership clubs). As shown, distribution of prevention activities varied widely statewide; for example, SASs in one ESD reported conducting 94 sessions from structured prevention curricula during the year, while SASs working within another regional ESD reported only 2 such sessions.

Group Intervention Sessions

Table 5 presents the number and types of group intervention sessions delivered. During 2022-23, SASs convened a total of 1,158 students and 215 groups (mean group size = 5.4 students). The most common intervention used was Coping with COVID-19 (85 groups, 420 students), a small group intervention that teaches students to develop coping skills based on principles of CBT and mindfulness (Rodriguez-Quintana et al., 2021). The second most common type of group were substance use focused (39 groups, 159 students), and included curricula for students beginning to use alcohol and other drugs, such as Teen Intervene (Winters, 2023). Less common groups included Alcohol, Tobacco, and other Drugs Education, which teaches students at risk of beginning substance use about the consequences and effects, and Affected Others, which supports students affected by others' substance use (e.g., family support groups).

Table 5. Types of Groups Conducted by Student Assistance Specialists

Group Type	N Groups	N Students Served	Mean Group Size (SD)	Mean N Group Sessions (SD)
Affected Others	15	67	4.5 (2.2)	7.9 (4.3)
ATOD Education	25	97	3.9 (1.7)	3.9 (2.2)
ATOD Intervention	36	159	4.4 (2.1)	6.7 (2.9)
Other Groups[a]	54	415	7.7 (6.9)	9.3 (15.2)
TRAILS Coping with COVID-19	85	420	4.9 (2.3)	7.0 (1.9)
Total	215	1,158	5.4 (4.1)	7.2 (8.0)

Note. ATOD = Alcohol, Tobacco, and Other Drugs.
[a] Other Groups included: Anger Management, Anxiety, Cognitive Behavior Therapy, Dialectical Behavioral Therapy, Divorce/Separation, Grief/Loss, Diversity, Social-Emotional Learning, Stress/Coping, Peer Support, Life Skills, Social/Restorative Justice, and Social Skills.

Table 6 presents details on the number of groups, group sessions, and students served by each of Washington's nine regional ESDs. Although SASs were distributed relatively equally statewide (6-9 per ESD), the number of groups convened varied greatly, from 7 to 56. Other variables related to group-based intervention also varied greatly, such as group size (ranging from 3.1 to 9.7).

Table 6. Summary of Group-Based Interventions Provided by Student Assistance Specialists, by Educational Service District (ESD)

	1	2	3	4	5	6	7	8	9	Total
Total Groups Conducted	9	19	14	41	34	22	56	13	7	215
Total N Students Served	56	113	77	179	185	213	249	40	46	1,158
Total N Sessions	63	278	105	274	260	150	301	62	60	1,553
Mean Students per Group	6.2	5.9	5.5	4.4	5.4	9.7	4.4	3.1	6.6	5.4
Mean Sessions per Group	7.0	14.6	7.5	6.7	7.6	6.8	5.4	4.8	8.6	7.2

Individual Intervention Services

Table 7 presents the number of individual intervention sessions delivered via Washington's BH-SAP. SASs reported a total of 2,532 students received individual service, with a range of 184-423 by ESD. These data indicate that each of Washington's 60 SASs worked individually with a mean of 42.2 students during the 2022-23 school year. As shown in Table 8, the most common type of service provided was individual counseling, received by 2,087 students, or 82% who were referred to the BH-SAP (range by ESD = 67% - 98%). Behavioral health screening was conducted for 1,826 students, or 72% of all students referred (range = 36% - 100%). Other services included providing information or referral to student's family (1,170 students; 46% of all served); care coordination (1,169 students; 46% of all served); and consultations with school staff (749; 30% of all served).

Table 7. Summary of Individual Intervention Sessions Provided by Student Assistance Specialists, by Educational Service District (ESD)

	1	2	3	4	5	6	7	8	9	Total
N Students Served	289	257	313	230	260	384	423	184	192	2,532
Total Student Sessions	2,844	3,428	2,690	1,851	2,736	4,159	2,906	1,175	1,139	22,928
Mean Sessions per Student (SD)	10.73 (9.15)	13.39 (18.45)	12.93 (11.95)	9.74 (7.29)	10.60 (8.76)	12.88 (12.86)	6.94 (7.07)	7.04 (5.04)	8.97 (5.91)	10.36 (10.92)

Table 8. Percent of all Students (N=2,523) who Received Each Intervention Service Provided by Student Assistance Specialists, by Educational Service District

Service Type	1	2	3	4	5	6	7	8	9	Total
Individual counseling	254 (88%)	172 (67%)	262 (84%)	165 (72%)	229 (88%)	313 (82%)	323 (76%)	181 (98%)	188 (98%)	2,087 (82%)
Behavioral health screening	104 (36%)	143 (56%)	194 (62%)	175 (76%)	258 (99%)	160 (42%)	423 (100%)	184 (100%)	185 (96%)	1,826 (72%)
Provide info or referral to family	47 (16%)	22 (9%)	116 (37%)	159 (69%)	246 (95%)	166 (43%)	209 (49%)	144 (78%)	61 (32%)	1,170 (46%)
Care coordination	106 (37%)	108 (42%)	148 (47%)	217 (94%)	70 (27%)	172 (45%)	84 (20%)	155 (84%)	109 (52%)	1,169 (46%)
Group counseling	60 (21%)	177 (69%)	46 (15%)	140 (61%)	171 (66%)	97 (25%)	118 (28%)	59 (32%)	4 (2%)	872 (34%)
Consult with school staff	79 (27%)	6 (2%)	113 (36%)	157 (68%)	66 (25%)	108 (28%)	73 (17%)	110 (60%)	37 (19%)	749 (30%)

Research Question 2: SAS Fidelity Overall and by ESD

As shown in the BH-SAP fidelity rubric presented in Table 3, the level of adherence to each of the 10 program components varied among the 60 SASs. The indicators that were met by the most SASs included student interventions (53% of SASs had 100% of enrolled students receive at least one intervention), groups (48% of SASs ran at least one TRAILS group), and student screening (40% of SASs screened 100% of enrolled students). The indicators that were met by the fewest SASs included behavioral health leadership clubs (17% of SASs had at least three club meetings per school), student referrals (10% of SASs had 100% of enrolled students with at least one referral made), and Parent and Community Trainings (10% of SASs had two or more events recorded). Total fidelity scores by ESD and statewide are included in Table 9. The average fidelity score across all 60 SASs statewide was .29 (29% out of 100%) with a range of 0-.8 (0 to 80%) and standard deviation of .215. The average score across ESDs ranged from 12% to 52%.

Table 9. Total BH-SAP SAS Fidelity by ESD

ESD	1	2	3	4	5	6	7	8	9	State
Mean	23%	33%	12%	47%	52%	27%	31%	25%	28%	29%
Min	0%	0%	0%	20%	40%	10%	0%	10%	20%	0%
Max	60%	70%	40%	80%	70%	50%	70%	40%	40%	80%
SD	0.206	0.269	0.103	0.242	0.130	0.189	0.254	0.129	0.110	0.215

Research Question 3: Outcomes for All Students and by SAS Fidelity

Table 10 presents results of analyses of change on the student survey from pre-intervention to post-intervention for all students in 6th grade or higher who completed an individual or group intervention with a SAS (as presented in the Methods, students below grade 6 did not receive pre- or post-tests). As shown in Table 10, significant improvement ($p < .001$) was found for all items in the Hope Scale, Social Connection, Mental Health Agency, and Internalizing Behaviors. Two of three Learning Supports items also were found to be significant at $p < .001$ (all except "I try to do well at school"). Ten of these 14 items demonstrated effect sizes in the small to medium range. Effect sizes for these items that showed significant improvement ranged from 0.228 (reductions in "feeling worthless or inferior") to -0.394 (improvement in "When I experience negative emotions, I have healthy strategies to calm myself down").

Table 10. Pre- to Post-Intervention Change for Students Receiving Individual Support from Student Assistance Specialists

Item	Pre M(SD)	Post M(SD)	N	t	Cohen's d
(Hope 1) I think I am doing pretty well.	3.49 (1.22)	3.88 (1.20)	1110	-9.89***	-0.30
(Hope 2) I am doing just as well as other kids my age.	3.16 (1.39)	3.57 (1.34)	1106	-9.62***	-0.29
(Hope 3) When I have a problem, I can come up with lots ways to solve it	3.24 (1.34)	3.67 (1.27)	1102	-9.83***	-0.30
(Hope 4) Even when others want to quit, I know that I can find ways to solve the problem	3.29 (1.36)	3.66 (1.30)	1104	-8.70***	-0.26
(Social 1) I have at least one close friend	4.96 (1.41)	5.13 (1.29)	1107	-3.65***	-0.11
(Social 2) I have at least one adult at school I can confide in	4.38 (1.64)	4.84 (1.38)	1104	-9.16***	-0.28
(Agency 1) I know how to ask for help when I need it	3.24 (1.50)	3.78 (1.43)	1102	-11.65***	-0.35
(Agency 2) When I experience negative emotions, I have healthy strategies to calm myself down	2.98 (1.36)	3.59 (1.34)	1102	-13.09***	-0.39
(Learning 1) I am happy to be at this school.	3.32 (1.53)	3.47 (1.49)	1105	-3.28***	-0.10
(Learning 2) I like what I am learning at school.	3.12 (1.43)	3.31 (1.42)	1103	-4.23***	-0.13
(Learning 3) I try hard to do well at school.	4.00 (1.42)	4.09 (1.39)	1090	-1.94*	-0.06
(Internalizing 1) I feel unhappy, sad, or depressed.	3.46 (1.46)	3.06 (1.38))	1094	9.12***	0.28
(Internalizing 2) I can't stop or control my worrying.	3.55 (1.58)	3.13 (1.50)	1095	8.02***	0.24
(Internalizing 3) I feel worthless or inferior.	2.91 (1.57)	2.55 (1.45)	1088	7.51***	0.23
(Behavior 1) In trouble at school	1.99 (1.22)	1.73 (1.10)	1108	7.25***	0.22
(Behavior 2) Suspended	1.28 (0.72)	1.17 (0.53)	1103	5.12***	0.15
(Behavior 3) Skipped school	1.86 (1.30)	1.81 (1.30)	1104	1.25	0.04
(Behavior 4) Arrested	1.03 (0.22)	1.04 (0.31)	1095	-1.21	-0.04
(Behavior 5) Physical fight	1.39 (0.90)	1.24 (0.68)	1102	5.34***	0.16
(Behavior 6) Hit or tired to hurt someone	1.43 (0.91)	1.29 (0.78)	1104	4.77***	0.14
(Substance Use 1) Had alcoholic beverages	1.23 (0.59)	1.23 (0.57)	1104	0.15	0.00
(Substance Use 2) Had five or more drinks in a row	1.12 (0.44)	1.12 (0.41)	1098	0.55	0.02
(Substance Use 3) Used marijuana	1.56 (1.11)	1.53 (1.10)	1097	1.04	0.03
(Substance Use 4) Used tobacco products	1.20 (0.73)	1.15 (0.64)	1084	2.02*	0.06
(Substance Use 5) Used an electronic cigarette	1.69 (1.29)	1.64 (1.25)	1098	1.49^{+}	0.04
(Substance Use 6) Used prescription drugs not prescribed to you	1.04 (0.33)	1.03 (0.26)	1099	1.40^{+}	0.04
(Substance Use 7) Used any other drug or substance	1.04 (0.23)	1.04 (0.28)	1093	-0.59	-0.02

*** $p < .001$ ** $p < .01$ * $p < .05$ $^{+}$ $p < .1$

In general, items assessing mental health agency and items from the Hope Scale showed the largest effect sizes among these items. Four items assessing behavioral incidents showed significant ($p < .001$) improvement: "In trouble at school," "Suspended," "Physical fight," and "Hit or tried to hurt someone." Effect sizes for these items ranged from d = 0.143 to d = 0.218. Two others ("Skipped school," "arrested") did not show significant change from pre- to post-intervention. Finally, none of the 7 substance use-related items showed significant improvement from pre- to post-intervention at $p < .001$, though "Used tobacco products" was significant at $p < .05$ (d = 0.061).

Table 11 presents t-tests and effect sizes representing the change on the student survey from pre-intervention to post-intervention for students who were served by SASs with high (.4 and above) and low fidelity (below .4) scores. Students in the high fidelity group reported significant changes from pre-post on 19 items, whereas students in the low-fidelity group reported significant pre-post changes on 15 items. When examining effect sizes, the high-fidelity subsample has 10 outcomes with small effect sizes (ranging from $\pm$ 0.228 to -0.409) and one with medium effect size (d = -0.509) whereas low-fidelity has eight outcomes with small effect sizes (ranging from $\pm$ 0.202 to -0.270) and none with medium effect sizes. For four items, the difference in effect size between high and low fidelity groups exceeded .1, all favoring

the high-fidelity group. For four additional items, the difference in effect size between high and low fidelity groups exceeded .2, also all favoring the high-fidelity group. These items with the largest discrepancy in effect sizes between groups (>.1) reflected hopefulness, having a trusted adult, mental health agency skills, and trying hard to do well at school, all favoring the high-fidelity group.

Table 11. Pre- to Post-Intervention Change for Students Receiving Individual Support from Student Assistance Specialists with High Fidelity and Low Fidelity

	High Fidelity				*Low Fidelity*				
Item	**Pre M(SD)**	**Post M(SD)**	**t**	**Cohen's d**	**Pre M(SD)**	**Post M(SD)**	**t**	**Cohen's d**	**D.i.d.** [a]
Hope 1	3.44 (1.19)	3.97 (1.14)	10.51***	-0.41	3.55 (1.28)	3.75 (1.26)	-3.10**	-0.15	-0.26
Hope 2	3.11 (1.37)	3.64 (1.29)	-9.95***	-0.39	3.23 (1.41)	3.47 (1.40)	-3.36***	-0.16	-0.22
Hope 3	3.24 (1.35)	3.75 (1.24)	-9.35***	-0.36	3.24 (1.32)	3.54 (1.32)	-4.21***	-0.20	-0.16
Hope 4	3.24 (1.34)	3.74 (1.28)	-8.90***	-0.35	3.35 (1.38)	3.54 (1.33)	-2.87**	-0.14	-0.21
Social 1	5.03 (1.35)	5.22 (1.18)	-3.59***	-0.14	4.86 (1.50)	4.99 (1.45)	-1.54^{+}	-0.07	-0.07
Social 2	4.39 (1.62)	4.89 (1.30)	-8.39***	-0.33	4.37 (1.68)	4.77 (1.50)	-4.53***	-0.22	-0.11
Agency 1	3.25 (1.49)	3.86 (1.40)	10.56***	-0.41	3.21 (1.51)	3.65 (1.46)	-5.65***	-0.27	-0.14
Agency 2	3.02 (1.36)	3.74 (1.28)	13.12***	-0.51	2.98 (1.37)	3.35 (1.39)	-5.28***	-0.25	-0.26
Learning 1	3.23 (1.46)	3.41 (1.43)	-3.42***	-0.13	3.47 (1.61)	3.57 (1.58)	-1.23	-0.06	-0.07
Learning 2	3.10 (1.36)	3.32 (1.38)	-4.05***	-0.16	3.15 (1.53)	3.29 (1.49)	-1.84*	-0.09	-0.07
Learning 3	3.91 (1.42)	4.09 (1.29)	-3.36***	-0.13	4.15 (1.41)	4.10 (1.54)	0.70	0.03	-0.16
Internalizing 1	3.46 (1.48)	3.04 (1.36)	7.51***	0.29	3.46 (1.44)	3.09 (1.41)	5.22***	0.25	0.04
Internalizing 2	3.50 (1.54)	3.09 (1.41)	6.37***	0.25	3.63 (1.64)	3.18 (1.63)	4.91***	0.24	0.01
Internalizing 3	2.87 (1.55)	2.52 (1.42)	5.84***	0.23	2.98 (1.60)	2.59 (1.49)	4.74***	0.23	0.00
Behavior 1	2.06 (1.26)	1.78 (1.11)	5.97***	0.23	1.90 (1.16)	1.66 (1.07)	4.14***	0.20	0.03
Behavior 2	1.29 (0.73)	1.18 (0.55)	3.97***	0.15	1.27 (0.69)	1.15 (0.49)	3.24***	0.16	0.00
Behavior 3	1.95 (1.33)	1.87 (1.34)	1.58^{+}	0.06	1.72 (1.24)	1.72 (1.26)	0.00	0.00	0.06
Behavior 4	1.03 (0.23)	1.04 (0.31)	-0.71	-0.03	1.03 (0.22)	1.04 (0.30)	-1.02	-0.05	0.02
Behavior 5	1.40 (0.93)	1.26 (0.72)	3.87***	0.15	1.37 (0.86)	1.21 (0.63)	3.72***	0.18	-0.03
Behavior 6	1.42 (0.89)	1.32 (0.83)	2.68**	0.10	1.44 (0.94)	1.24 (0.68)	4.21***	0.20	-0.10
Substance Use 1	1.27 (0.66)	1.26 (0.60)	0.57	0.02	1.16 (0.45)	1.17 (0.51)	-0.52	-0.02	0.05
Substance Use 2	1.15 (0.48)	1.14 (0.44)	0.34	0.01	1.09 (0.38)	1.08 (0.36)	0.47	0.02	-0.01
Substance Use 3	1.68 (1.19)	1.65 (1.19)	0.70	0.03	1.38 (0.96)	1.35 (0.91)	0.81	0.04	-0.01
Substance Use 4	1.22 (0.76)	1.18 (0.70)	1.48^{+}	0.06	1.16 (0.69)	1.11 (0.53)	1.42^{+}	0.07	-0.01
Substance Use 5	1.81 (1.38)	1.74 (1.32)	1.70*	0.07	1.50 (1.12)	1.49 (1.12)	0.20	0.01	0.06
Substance Use 6	1.06 (0.38)	1.03 (0.29)	1.26	0.05	1.02 (0.24)	1.02 (0.21)	0.62	0.03	0.02
Substance Use 7	1.04 (0.25)	1.06 (0.34)	-1.09	-0.04	1.03 (0.20)	1.02 (0.14)	0.89	0.04	-0.09

[a]Difference in Cohen's d effect sizes (high fidelity group – low fidelity group)
*** p < .001 ** p < .01 * p < .05 $^{+}$ p < .1

Satisfaction with BH-SAP Services

The post-survey administered after students complete a full intervention asks three questions about their satisfaction with the program. Among students who responded to each item (n = 1,049 − 1,061), 96.8% reported that the program was somewhat or very helpful to them and 96.5% reported being glad they participated in the program. Finally, of the 574 students with low school attendance, 82% reported being more likely to attend school due to the program.

Discussion

The current study provides one of the first evaluations of a statewide BH-SAP utilizing paraprofessional Student Assistance Specialists (SASs) to address youth behavioral health needs in schools. Results demonstrate that SASs filled common gaps in the continuum of school supports, delivering a substantial volume of prevention and intervention services across the tiers of support, though relative rates of expected Tier 1 and 2 activities varied substantially by region. Students who received BH-SAP services reported significant improvements in hope, social connection, and coping, and reductions in internalizing symptoms and behavioral incidents, with greater adherence to the BH-SAP fidelity rubric associated with more positive student outcomes. Students reported overwhelmingly positive satisfaction with BH-SAP services. These findings have important implications for addressing the behavioral health workforce crisis and for enhancing the continuum of services within school-based mental health systems.

Leveraging Paraprofessionals to Expand Service Delivery

During a period of unprecedented behavioral health needs among youth (Ivey-Stephenson et al., 2020; Yard et al., 2021), the Washington State BH-SAP demonstrated that paraprofessionals with associate and bachelor's degrees can provide a substantial volume of services across multiple domains of prevention and intervention. Over the course of the 2022-23 school year, approximately 70 SASs conducted over 3,200 prevention activities statewide, provided group interventions to over 1,150 students, and delivered individual interventions to more than 2,500 students. These findings align with previous research showing paraprofessionals can successfully implement a range of prevention and early intervention services in school settings (Hart et al., 2023; McQuillin & McDaniel, 2021; Strait et al., 2020).

The volume of services provided by SASs is particularly notable given the severe shortages of credentialed mental health professionals in schools. With school psychologist-to-student ratios exceeding 2,000:1 in some states (Affrunti, 2025) and similar trends for school counselors and social workers, the integration of paraprofessionals offers a practical approach to expanding the capacity of the school behavioral health workforce to provide the types of services documented in this study. As shown in Tables 4, 5, 6 and 7, SASs provided extensive total volume of prevention, early intervention, and coordination activities that fall within their scope of practice, potentially allowing schools to free up licensed clinicians and school-employed professionals with more specific expertise to focus on students who require more intensive or specialized support.

Regional Variations in Service Delivery

Examination of number of sessions delivered by region (Tables 4, 5, 6 and 7) help provide a picture of the typical duties of an SAS working within the BH-SAP program, while demonstrating the wide local variation in SAS programming. For example, the mean number of mental health awareness presentations was 2.4, but individual SASs ranged from 0 to 30 such sessions during the school year. The SAS who delivered 30 sessions may have spent this time systematically delivering the six 45-minute sessions of the teen Mental Health First Aid (tMHFA; Wilcox et al., 2023) curriculum to five different classrooms. Other SASs may have provided individual sessions to just 1–2 classrooms, at the request of specific teachers. This variation was by design– the goal for year 1 of the BH-SAP was for SASs to deliver a range of Tier 1 prevention activities at minimum levels to establish SASs' skills, build pathways for referral to Tier 2 and 3 supports, and learn how best to support statewide implementation. Beyond these minimum expectations, SASs were expected to be responsive to schools' individual needs.

Regional Variations in Adherence

Exploration of adherence to the BH-SAP rubric highlight both the promise and challenges of this statewide framework. As shown in Tables 3 and 9, adherence rates to the BH-SAP fidelity framework varied considerably across components, with higher adherence to individual intervention elements (36–48%) compared to prevention activities (13–28%).

This pattern likely reflects that BH-SAP was a relatively new statewide program in 2022-23. SASs, their supervisors, and regional ESD coordinators were still learning how best to oversee and manage implementation of BH-SAP. In fact, although the BH-SAP model had been developed and expectations set, formalization into a concrete measurable rubric was not yet complete.

In addition, the 2022-23 school year also was the first school year with a full return to school after two years of full or partial remote learning. Not only were schools and ESDs facing competing priorities during the COVID-19 pandemic recovery period, students also were returning to school after substantial COVID-related traumas and disruptions.

Second, for many schools, serving individual students in need was viewed as a higher priority than prevention and community outreach activities, especially during the COVID-19 pandemic. For example, the ESD with the lowest overall fidelity (12%) reported that they chose to focus on individual services to students in year 1 of the program (as opposed to classroom or group components of the BH-SAP model), in response to appeals from school building leaders for individual and group treatment to address multiple traumas experienced by their students. Such findings underscore that local context significantly influences how paraprofessionals integrated into school buildings and districts, with some emphasizing group-based interventions, while others focused more heavily on individual supports or universal prevention activities.

Leadership factors also were observed to influence fidelity to the program model. ESDs with the highest fidelity (52% and 47%), were observed by state coordinators to have the most stable and committed Directors and BH-SAP Coordinators.

A final hypothesis is that schools in more rural or underserved regions may demonstrate different levels of fidelity, services provided, student outcomes, or other variables presented here. Unfortunately, examining student outcomes by resource level and urbanicity is challenging because all analyses here focused on variation by ESD, most of which serve diverse regions with both urban and rural areas, as well as well-resourced and under-resourced districts. Although outside the scope of this paper, future analyses will evaluate fidelity and service mix at the district and school levels, as well as their impact on student outcomes. Such results will also shed light on whether and how the BH-SAP model may reduce (or inadvertently widen) inequities.

In sum, fidelity and service delivery was found to vary widely across ESDs. Such variation underscores the degree to which the BH-SAP model can and will be flexibly applied to fit local context, resources, and student needs. However, the observed variation also indicates the need for robust implementation supports in order to maintain adherence to core elements of the fidelity rubric, such as general and EBP-specific training and coaching, supervision by a licensed clinician, monthly community of practice meetings, and measurement and feedback at multiple levels.

Student Outcomes and Program Effectiveness

Mental Health Outcomes.

The significant improvements observed across multiple domains of student functioning provide encouraging preliminary evidence for the potential for positive effects of paraprofessional-delivered school behavioral health services. Particularly notable were the moderate effect sizes for improvements in mental health agency (d = 0.35-0.39), hope (d = 0.26-0.30), and reductions in internalizing symptoms (d = 0.23-0.28). These outcomes suggest that individual and group interventions provided by SASs were especially effective at building coping skills, fostering optimism about the future, and reducing symptoms of anxiety and depression. This pattern of outcomes aligns with the focus of many SAS-delivered interventions, such as the TRAILS program (Rodriguez-Quintana et al., 2021),

which emphasizes cognitive-behavioral strategies for managing anxiety and depression.

Although the current study did not include a control group, effect sizes for symptoms for the current study are comparable to those we have found in studies of school-based services delivered by licensed, Masters-level clinicians. For example, in one study (Bruns et al., 2023), we found mean within-group improvement from baseline to three months for high school students to be d = 0.29 for anxiety and d = 0.33 for depression. Such comparisons are far from conclusive, and it is important to note that SASs are asked to address problems beyond anxiety and depression, including substance use, likely reducing impact on internalizing symptoms. Nonetheless, these results suggest that paraprofessionals can achieve impacts similar to licensed clinicians when provided with appropriate training, supervision, and evidence-based intervention materials.

Other Outcomes.

Improvements in school engagement and behavioral outcomes were more modest, and changes in student-reported substance use were minimal, indicating areas where Tier 2 interventions within the BH-SAP model may need refinement. These findings are consistent with previous research suggesting that different behavioral health concerns may require varying levels of school-based intervention intensity and specialization (Center for School Mental Health, 2018). Results also underscore the potential importance of integrating BH-SAP within a tiered model that strategically refers students to providers with specialized training and expertise in order to address the full spectrum of student needs.

Implications for Workforce Development

The current study contributes to the growing literature on task shifting and workforce expansion strategies in behavioral health, indicating that associate and bachelor's level paraprofessionals, working within a supervised practice structure, can provide a range of Tier 1 and 2 school behavioral health services and be viewed as effective by students and school leaders alike.

Critical to the success of the BH-SAP model was the comprehensive infrastructure provided through the regional ESDs. At the state level, this infrastructure included standardized training sequences, regional coordination with regular state-wide meetings of regional BH-SAP Coordinators, and robust evaluation including outcomes and fidelity monitoring with feedback to the regional ESDs. At the local level, regional ESDs provided ongoing coaching including review of outcomes and fidelity data and clinical supervision by licensed professionals. Without such supports, paraprofessional providers may be less likely to implement evidence-based practices effectively or maintain appropriate boundaries of practice. This aligns with findings from other paraprofessional models in behavioral health that emphasize the importance of systematic training and supervision (McQuillin et al., 2021).

Results showing associations between fidelity to the BH-SAP framework and improvements in student outcomes reinforce the potential importance of working within a defined structure. Though exploratory at this point, these preliminary findings suggest that providers that are able to consistently follow-through on expectations such as screen all students using standardized measures, participate fully on school teams, and deliver a range of Tier 1 and 2 programming are also more effective at addressing student needs.

Finally, the BH-SAP model can be an effective strategy for building the behavioral health workforce by providing a potential career ladder entry point for future practitioners. Many SASs in Washington were concurrently enrolled in higher education programs, suggesting that these positions could function similarly to apprenticeships or internships for individuals interested in behavioral health careers. This "grow your own" approach may be particularly valuable for addressing workforce shortages in rural and underserved communities where recruiting specialized providers has been historically challenging.

Limitations

Several limitations should be considered when interpreting the findings. First, as discussed above, the pre-post design without a comparison group limits causal inferences. Second, reliance on student self-reported outcomes without independent assessments or academic performance data provides a limited perspective on program impacts. Third, tests of association between fidelity and outcomes were exploratory, and criteria for the two groups were created solely to provide equal groups rather than a threshold based on research or prior theory.

Future research should address these limitations through more rigorous evaluation designs. Furthermore, investigations of the specific mechanisms through which paraprofessionals effectively support student mental health are needed to enhance understanding of BH-SAP effectiveness as well as how best to optimize the role of SASs within comprehensive school mental health systems.

Future Directions

From a policy perspective, further exploration is needed regarding sustainable funding mechanisms for paraprofessional roles such as SASs. Washington's BH-SAP was launched in 2021 at 51 sites using federal Elementary and Secondary School Emergency Relief (ESSER) funding. In 2023, after extensive stakeholder engagement and feedback of encouraging evaluation results, BH-SAP received a onetime investment from the state legislature, allowing for the expansion of services to over 60 sites. After expiration of ESSER funding in 2024, BH-SAP was sustained by state general fund and local dollars; however, at reduced levels.

With expiration of federal COVID relief funds– and subsequent further reductions in federal grant support to student services– many states and school districts are now seeking comprehensive strategies to maintain and expand critical services such as BH-SAP. We are pursuing a multi-pronged sustainability strategy that includes advocacy for dedicated state funding and other policy changes, providing technical assistance to local jurisdictions and communities on how to integrate BH-SAP components into existing district policies and procedures, and exploration of state and regional strategies for developing cost-effective training, supervision, and credentialling of BH-SAPs.

Finally, given success in other states (Hoover, 2024), development of Medicaid billing infrastructure is being explored. However, implementing Medicaid billing requires substantial infrastructure development, including staff credentialing, documentation systems, and administrative oversight. To address these issues, the State BH-SAP Lead participates in the State Medicaid Charter Workgroup and is actively exploring opportunities to sustain and scale the model through Medicaid funding.

Finally, best practices for supervising paraprofessionals such as SASs are needed for this model to be scaled in other localities. Not all states have entities such as Washington's ESDs, the majority of which are qualified mental health provider agencies with licensed staff available to supervise SASs. Certification pathways, reimbursement models, and career advancement opportunities for paraprofessionals in school behavioral health need to be established, evaluated, and promulgated if we are to solidify such positions within the workforce.

Conclusion

The behavioral health workforce crisis in the United States requires innovative approaches that expand service capacity while maintaining quality of care. The current study suggests that paraprofessional Student Assistance Specialists, when properly trained and supervised within a structured program model, can meaningfully contribute to addressing youth behavioral health needs in schools. By complementing rather than replacing specialized providers, paraprofessionals can help extend the reach of evidence-based prevention and early intervention strategies. As schools continue to face increasing demands to support student mental health, models like BH-SAP

offer promising pathways for building a more robust, diverse, and accessible behavioral health workforce capable of meeting the full spectrum of student needs.

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