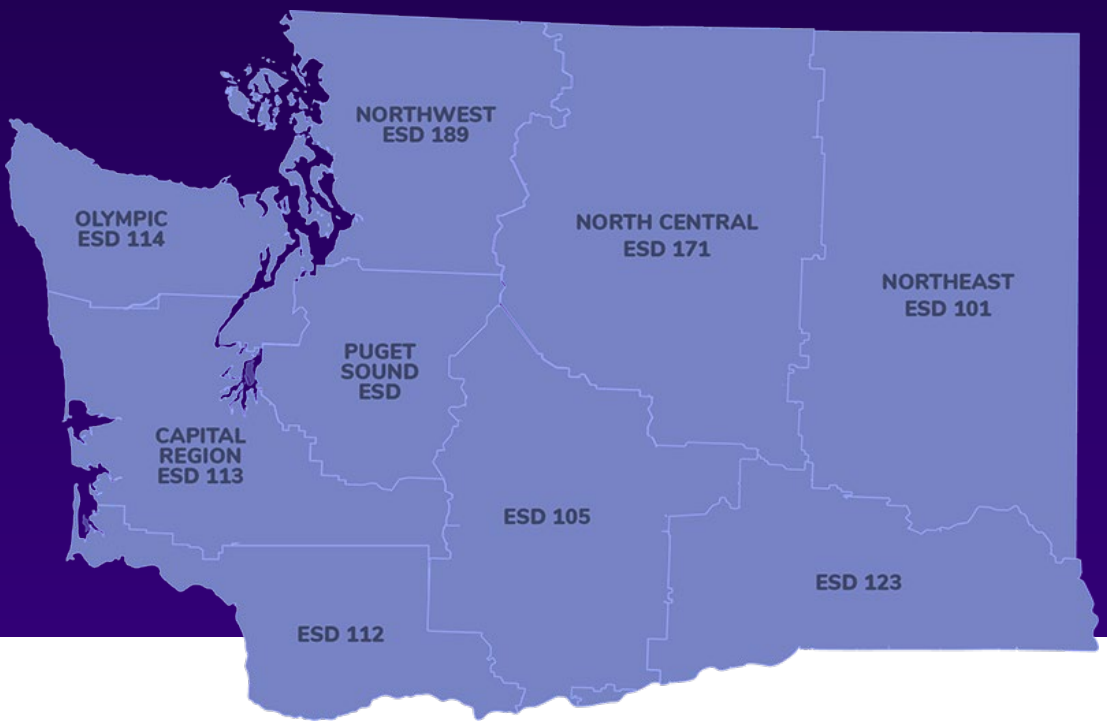

Washington State Behavioral Health Student Assistance Program

2024-2025 Annual Report

August 2025

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In collaboration with:

Washington State Association of Education Service Districts (AESD)

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Introduction

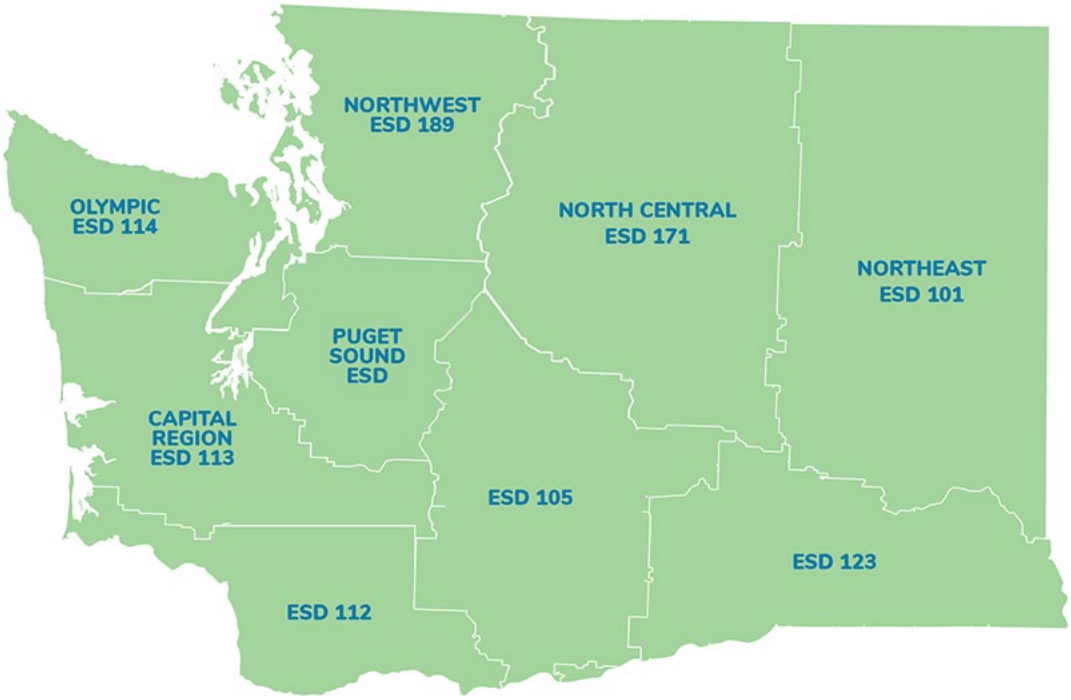
The **Washington State Behavioral Health Student Assistance Program (BH-SAP)** is a research-based, statewide model that places trained Student Assistance Professionals (SAPs) in schools to deliver prevention, early intervention, and referral support within Washington's **Multi-Tiered System of Support (MTSS) framework**. Funded through a strategic legislative investment, WA BH-SAP increases early identification of behavioral health needs, expands the workforce pipeline, and strengthens school–community partnerships, providing support to thousands of students each year. Backed by strong statewide coordination and rigorous evaluation, BH-SAP reduces barriers to care and aligns with state priorities for youth mental health. Moreover, multiple years of data collection show the program measurably improves schools' capacity to respond to student needs, reaches far more students than traditional school behavioral health models, and demonstrably improves student well-being.

This report details the scope and impact of services provided to school communities throughout the 2024-25 school year (August 1, 2024 – July 1, 2025) to examine progress towards intended outcomes and adherence to the student support model.

Program Overview

The grantees include the state's nine Educational Service Districts (ESDs). ESDs serve as an effective, efficient, and high-quality regional delivery system that supports Local Education Agencies (LEAs) through capacity building, professional learning, and delivers site- and student-based direct services that address the plethora of student assistance needs. Across the ESD network, behavioral health services have been delivered through a variety of programs and funding sources for over 30 years.

Figure 1 Washington State's 9 ESDs



The central method through which the BH-SAP provides enhanced support to student wellness is via funding to Student Assistance Professionals (SAPs), an expansion and enhancement of the Student Assistance Prevention-Intervention Services Program (SAPISP). SAPSIP is a comprehensive, integrated model of services that fosters safe school environments, promotes healthy childhood development, and provides prevention and intervention services for alcohol, tobacco, and other substance use. SAPs provide services such as counseling, referrals, family contact, skill development, and support groups to students in need. SAPs also make presentations on relevant behavioral health and prevention topics and implement curricula and activities to all students.

The BH-SAP provides funding for 18 site-based SAPs, 9 regionally based Coordinators, a statewide ESD Network system lead, and a statewide data manager. A logic model for the project is presented below and in the Appendix. As shown, the availability of the SAPs is proposed to be a central mechanism through which outcomes at the Local Education Agency (LEA) and school (building) levels will be achieved, as well as, ultimately, student outcomes such as improved awareness of and access to behavioral health services, improved mental and emotional wellness, and better academic outcomes. In addition to local support from ESDs, training and professional development to SAPs is provided from sources such as TRAILS to Wellness (providing support to implement group and individual cognitive behavioral therapy and wellness activities). Another layer of support is provided through dedicated, regional MTSS coordinators who partner with OSPI to work with

identified districts. Finally, the UW SMART Center is aiding the BH-SAP initiative with program evaluation.

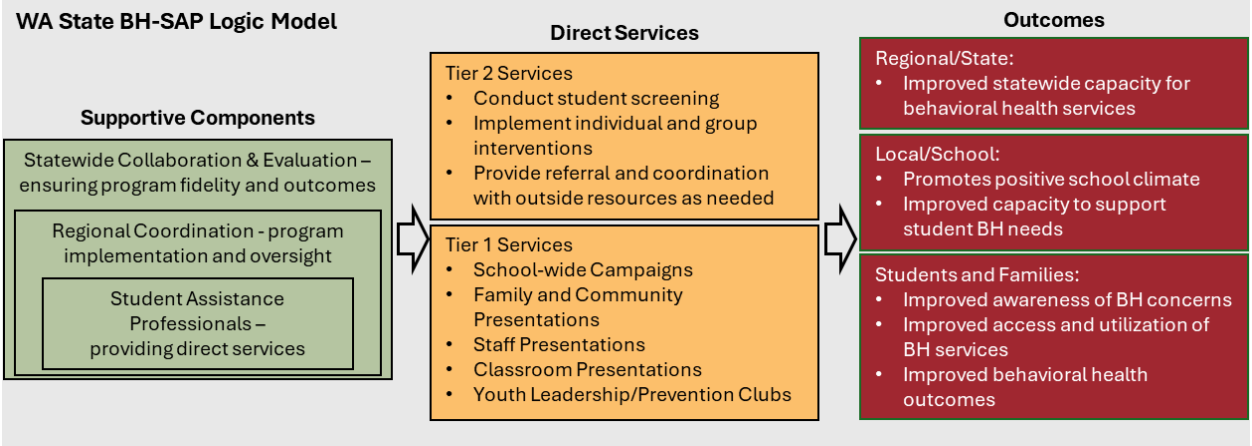
Across multiple tiers of support, regional and site-based staff provide a continuum of care, as appropriate under their existing delivery systems model and scope of licensure, with primary focus on supporting sites and students at Tiers 1 and 2; and referral/linking students to services at Tier 3. This approach is validated through Academic & Student Well-Being Plans, in which over 1/3 of LEAs indicated need for support with Multi-Tiered System of Supports and social emotional learning/mental health supports (as of 6/22/21). See AESD Statewide Behavioral Health Student Assistance Program Adherence Evaluation Plan for more detail about the program components.

Evaluation Components

The UW SMART Center provides program evaluation and data support. All evaluation activities are completed in collaboration with the coordinators and SAPs, providing information relevant to the implementation and effectiveness of the BH-SAP. As indicated in the logic model, key evaluation and continuous quality improvement questions include:

- What are SAPs doing in schools?
- Are students being identified and referred?
- Are students served experiencing more positive behavioral health outcomes?

Figure 2 Logic Model for the BH-SAP



Respondents and Data Sources. The principal source of data for this report is the online database maintained by Looking Glass Analytics (LGAN). This secure, web-based reporting system is used to collect information about BH-SAP activities and outcomes. SAPs enter information detailing: universal activities offered to all students, selective and indicated prevention/intervention services provided to referred students, and program outcomes for participating students.

Students referred for selective and indicated prevention activities in Grades 6–12 complete a survey before and after participation. The survey is administered confidentially via scantron or computer, and items address hopefulness, behavioral health symptoms, and satisfaction with services. These measures satisfy federal and state reporting requirements. In addition to student participant surveys, district and building staff members are surveyed once per school year to gather input about the impact of the services provided by the BH-SAP.

Data Analysis Paired sample t-tests are used to compare the difference in means between pre- and post-test measures. Differences with a p-value less than 0.05 were considered significant differences. Analyses are conducted with IBM SPSS Statistics 29.

BH-SAP Services Provided in 2024-25

This section describes BH-SAP activities in the 2024-25 school year including the number of personnel and sites involved, number and characteristics of students served, and number and types of services provided to students, families, staff, and school communities.

Project Continuation

To ensure alignment and coherence was maintained, the ESD Network system lead coordinates across the ESDs and with state program partners. Alignment efforts include program development, installation/upkeep of evaluation and record-keeping systems, and the provision of various professional learning and technical assistance services. Student assistance professionals attend annual trainings and regular project meetings to ensure a shared understanding of program goals and requirements to support effective delivery of the identified program model.

LEAs and Schools Served

Regional ESD teams leverage their in-depth knowledge and relationships with LEAs to support efficient placement of the site-based SAP positions. These positions are deployed in LEAs and schools based on site demographics, need, and readiness. In the 2024-25 school year, BH-SAP services have been provided in **18 LEAs and 24 schools** (presented by ESD in Table 1), with all placements at the middle and high school levels (shown in Table 2).

Table 1 BH-SAP Sites

ESD	101	105	112	113	114	121	123	171	189	Total
SAPs	2	2	2	2	2	2	2	2	2	**18**
LEAs	2	2	2	2	2	2	2	2	2	**18**
Schools	2	2	2	3	2	2	3	5	3	**24**

Table 2 BH-SAP School Levels

School Type	Grade Levels	Number	Student Enrollment
Middle School	6-8	13	7,352
High School	9-12	11	7,153
Total	**6-12**	**100**	**14,505**

Characteristics of Students Served

Of the 837 students receiving quick or full intervention services from SAPs in 2024-25, the majority were self-referred (49%), identified through non-discipline channels (80%), and enrolled in middle schools (56%). Services were provided to slightly more female (56%) students than male students (40%) and a small number of students who identify with other gender identities (4%). (See Chart 1 and Table 3 below for additional demographic detail).

Compared to all Washington students, SAPs served a similar group of students, with a few exceptions: Asian students were less prevalent (making up 9% of all students enrolled statewide but 1% of those served by SAPs) and White, non-Hispanic students were more prevalent (48% statewide and 58% served by SAPs) (OSPI, 2025).

Chart 1 Demographic Characteristics of Students Served in 2024-25

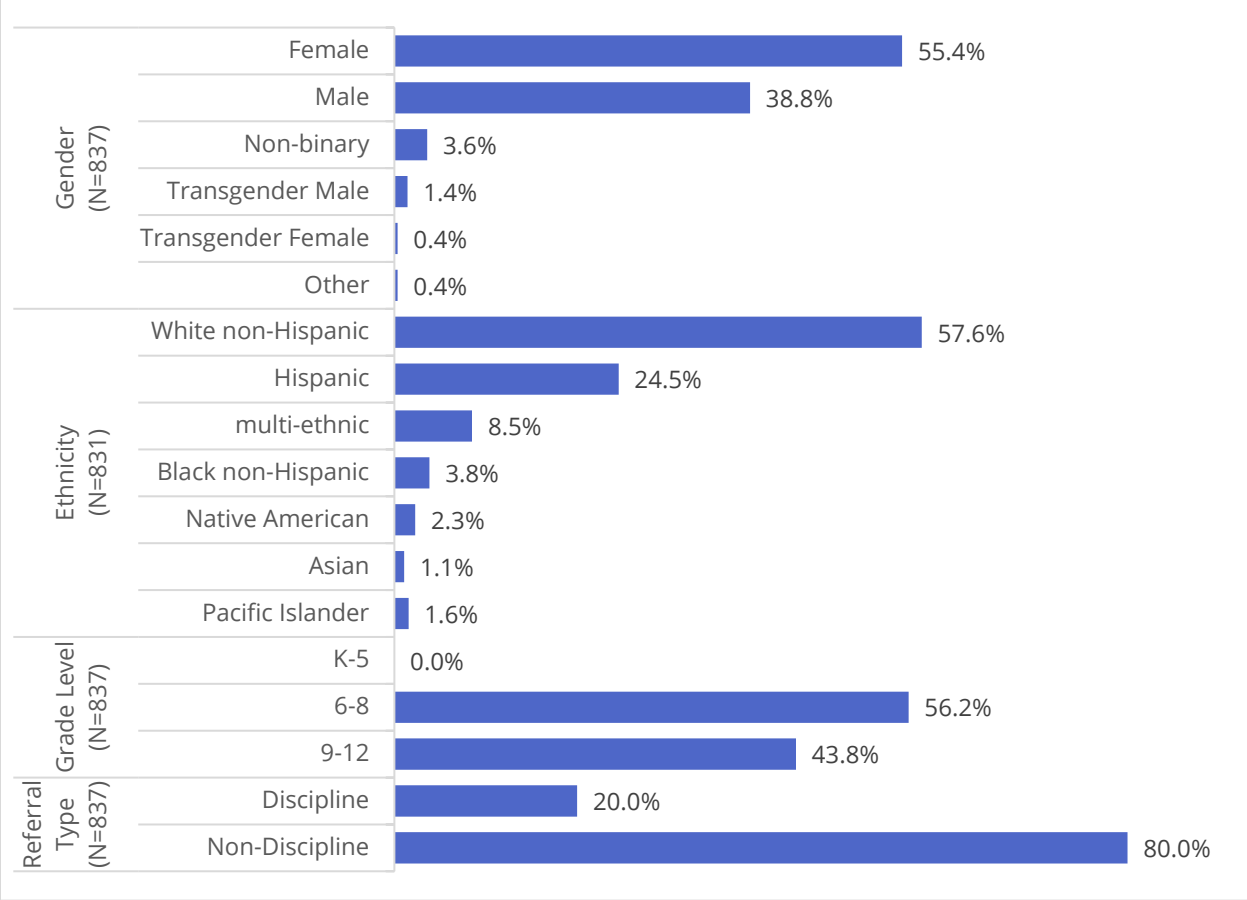


Table 3 Student Referral Sources in 2024-25

Source	Students with Referral Source	Percent of Students Served
Core Team	103	12.3%
Administrator	218	26.0%
Teacher	74	8.8%
Counselor	162	19.4%
Interventionist	11	1.3%
Other school staff	36	4.3%
Self	414	49.5%
Parent	73	8.7%
Peer	51	6.1%
Other agency	2	0.2%

Services Provided

SAPs provide a wide array of services that are common to student assistance programs (Anderson, 1993), with a **primary focus on universal prevention (Tier 1) and early intervention (Tier 2)** (Table 4). The following sections present details on universal prevention and early intervention services provided by SAPs.

Table 4 Services Listed by Tier

Tier 1 Universal Prevention	Tier 2 Early Intervention
• Delivery of classroom curriculum • Promote program awareness among staff • Family/community education • School/community presentations • Prevention planning	• Identification and screening • Care coordination • Early intervention (individual and group) • Referral to in-school programs or community services • Consultation with Multi-Disciplinary Teams

Universal Prevention Services

Universal services are provided to the whole school or all students in one or more specific grade levels. Some services are recurring (with multiple sessions per activity). For each service, the following tables present the number of unique activities, total sessions, total participants, and average hours per session conducted by SAPs for student audiences (Table 5) and school staff, families, and the general community (Table 6).

As shown in Table 5, ***awareness events*** account for the largest number of student universal prevention activities. This category includes mental- and behavioral- health awareness presentations and campaigns, information dissemination efforts, and presentations about program services. In the 2024-25 school year, **371 student awareness events were provided by the BH-SAP statewide**. This year's four Statewide Awareness Campaigns included: *Suicide Prevention, Bullying Prevention, Substance Use Prevention, and Mental Wellness*.

In addition to awareness events, throughout the 2024-25 school year, SAPs taught students important ***social-emotional and life skills*** through **190 evidence-based lessons**. This year's student curricula included: *Character Strong, In the Know on Nicotine, Social Emotional Learning (SEL), and teen Mental Health First Aid (tMHFA)*.

Table 5 Universal Prevention Services for Students 2024-25

Activity Type	Activities	Sessions	Total Participants	Average Hours per Session
Awareness	**371**	**371**		
Presentation about services	47	47	2,403	0.4
Information dissemination to students	36	36	23,103	0.6
Behavioral health awareness event	145	145	75,921	1.2
Presentation about behavioral health issues	143	143	6,661	0.9
Curriculum	**16**	**190**		
Other recognized prevention curriculum/ program	16	190	398	0.9
Education	**101**	**263**		
Newcomers Group	10	17	45	0.6
Prevention education series	11	61	291	0.9
Stress, Anxiety and Coping Skills Presentation	54	54	1,466	0.9
TRAILS SEL	26	131	1,102	0.6
Peer	**34**	**255**		
Behavioral Health Leadership Clubs	34	255	2,268	0.8
Total	**522**	**1,079**		

In conjunction with student-focused efforts, universal prevention activities geared towards ***staff, families, and the community*** focused on increasing awareness of the issues and needs of students and are categorized as either awareness or planning services. As shown in Table 6, planning activities accounted for the largest number of sessions (380) with **screening and referral services** being especially prevalent (326). In addition, SAPs **promoted parent and family awareness** through 14 presentations and 60 information dissemination campaigns on a range of topics and resources, including: *Alcohol Tobacco and Other Drugs (ATOD) Prevention/Red Ribbon Week, Coping Skills, Friends for Life, Healthy Relationships, Information about SAP Services, Stress Reduction, Mental Health, Parent's Night Out, Self-Care, Suicide Prevention, and Unity Day*.

Table 6 Universal Prevention Services for Staff, Families, and Communities '24-25

Activity Type	Audience	Activities	Sessions	Total Participants	Average Hours per Session
Awareness		**143**	**143**		
Information dissemination to community	Community	9	9	2,215	0.7
Community presentation	Community	15	15	309	1.7
Awareness presentations to parents	Family	14	14	389	1.4
Information dissemination to parents	Family	60	60	20,183	1.6
Staff awareness presentations	Staff	29	29	1,147	0.4
Information dissemination to staff	Staff	16	16	638	0.5
Planning		**86**	**380**		
Community Planning	Community	21	21	161	1.1
Policy and procedure development and implementation	Staff	7	17	62	0.9
Technical assistance/consultation	Staff	16	16	732	1.2
Screening and referral services	Staff	42	326	304	0.9
Total		**229**	**523**		

Early Intervention Services

During the 2024-25 school year, **837 students in Washington State received early intervention services through the BH-SAP**. In addition to providing screening and individual and group intervention services, SAPs refer students to school-and community-based resources, coordinate care with external providers, connect with family members, and consult with school staff regarding student issues. Chart 2 displays the percentage of students who received the most common individual or group services. The most common individual supports were: BH screening (95% of students), individual interventions (68%), care coordination (64%), and providing information or referrals to families (50%). The most common group services were as follows:

- TRAILS Coping Skills (CBT-based group intervention) teaches students to learn and practice helpful, healthy strategies for managing symptoms of stress, low-mood, or increased worry.
- Other supportive services include any other group support (e.g., grief groups, children of divorce groups, victims of abuse groups)
- Intervention groups help students with their own substance use.
- Affected Others/ COSAPs support students affected by others' substance use
- Alcohol, tobacco, and other drug (ATOD) education classes teach students at risk of beginning substance use about the consequences and effects.

Chart 2 Percent of Students Receiving Most Common Individual and Group Services '24-25

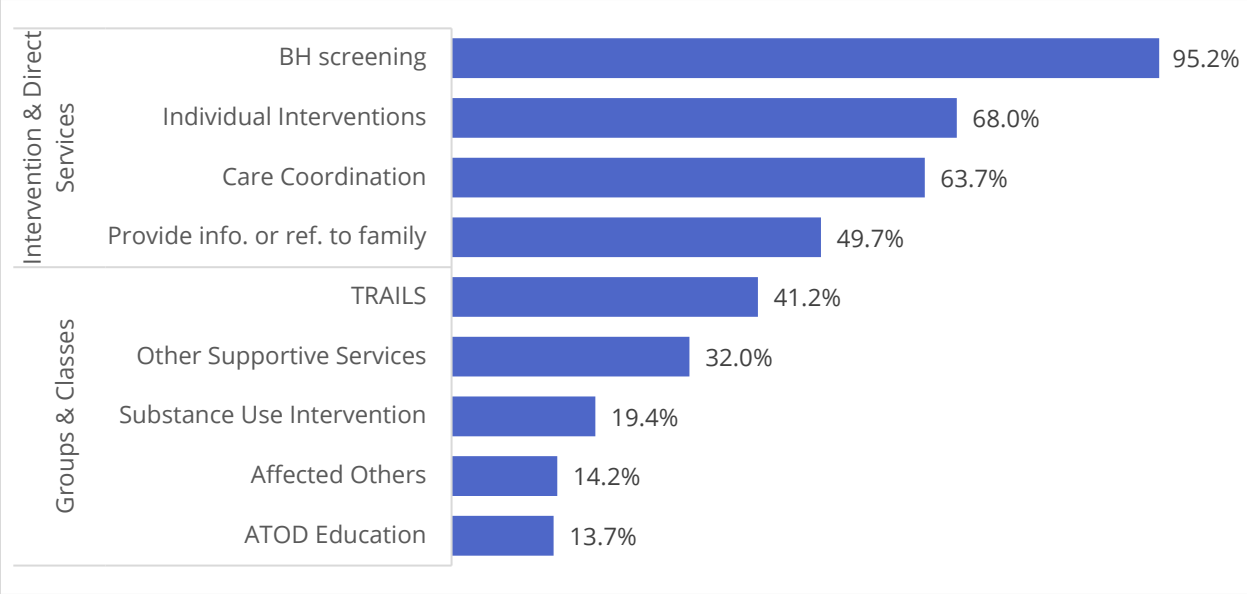


Chart 3 displays the total number of groups conducted by Student Assistance Professionals while Chart 4 shows the number of students enrolled by group type. In total, **144 Groups were conducted with 622 students**. The average number of students per group was four and the average number of sessions per group was seven. The majority of these students (78%) were enrolled in one group, but some were referred to as many as 4. The most common group was **TRAILS Coping Skills** (65 groups with 293 students).

Chart 3 Groups Conducted '24–25

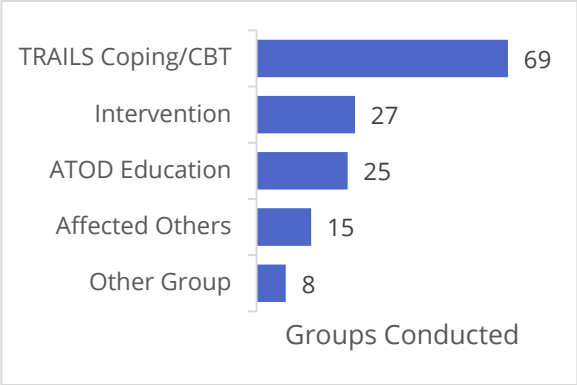
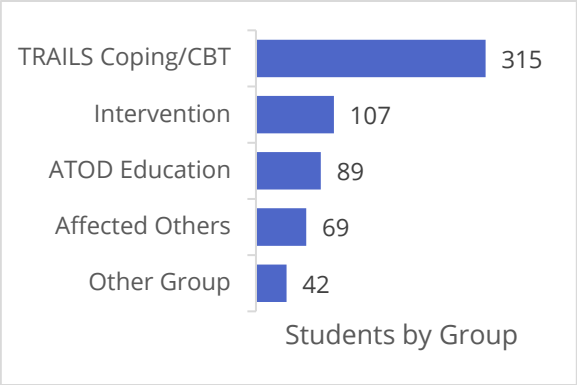


Chart 4 Students Enrolled in Groups '24-25



Service Dosage

Of the **837** students who received direct services from SAPs, **86% were full interventions** (Chart 5). As mentioned previously, the type of support varied based on student need, but the most common included individual counseling, behavioral health screening, and providing information or a referral to the family. The amount of time spent supporting each student also varied, but on average, totaled to **about 3 contacts per student for quick interventions** and 11 contacts for full (Chart 6).

Chart 5 Students Receiving Quick or Full Interventions '24-25

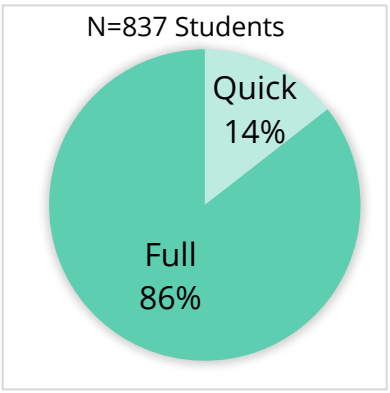
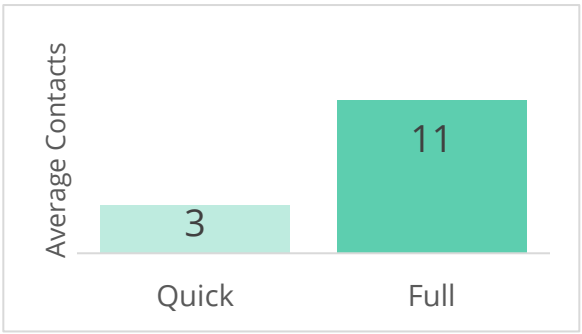


Chart 6 Average Number of Student Contacts '24-25



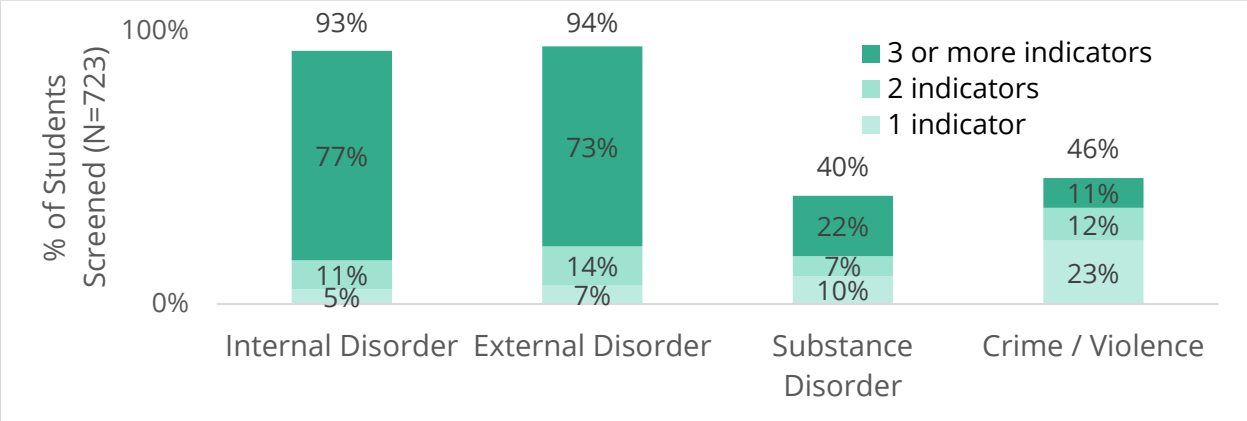
Contacts	N	Min	Max	Mean	St. Dev.
Quick	121	1	13	3.3	2.57
Full	716	1	38	10.5	6.15

Screening for Substance Use and Mental Health Issues

Student Assistance Professionals 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). This brief instrument was developed to identify youth in need of formal treatment. Washington's DBHR requires the use of the GAIN-SS through contract and requires that a student exhibit a minimum of three of the listed indicators to be admitted to community-based substance treatment. The measure consists of four, 5-7 item subscales that assess whether a student may have internalizing disorders, externalizing disorders, substance use disorders, and crime or violence problems. 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.

In 2024-25, **723 students** completed a GAIN-SS screening and had valid subscale scores. Of those students, **93%** had at least 1 indicator of an **internalizing disorder** and **94%** had at least 1 indicator of an **externalizing disorder** (Chart 7).

Chart 7 GAIN-SS Screening Results 2024-25



Note. Subscale scores that were over the total possible score of 6 for Internal Disorders, 7 for External Disorders, or 5 for Substance Disorder or Crime/Violence Problems (indicating data entry errors) were not included.

BH-SAP Effectiveness and Outcomes

As described in the Introduction, the BH-SAP seeks to advance student behavioral healthcare using a dual approach of expanding school-based behavioral health services across the state while investing in much-needed foundational capacity building at the regional and local levels that is necessary for long-term sustainability. The following sections describe the progress made towards achieving these goals; beginning with student-level outcomes and followed by impacts on the school, district, and region.

Student-Level Impact

To assess the impact of BH-SAP services for participating students, the UW SMART Center and AESD worked together to coordinate collection of survey data from students on satisfaction, wellbeing, and behavioral health symptoms via a self-report survey. This survey is administered before and after full interventions (see Table 7).

Table 7 Student Data Collected by Type of Intervention

Intervention Level	Data Collected
Quick: received behavioral health screening and two or fewer contacts with SAP	• Demographic Information & BH Screening • Log of Services Received
Full: received behavioral health screening and had three or more contacts with SAP	• Demographic Information & BH Screening • Log of Services Received • **Pre/Post Survey** (6th grade and up only)

Student Engagement in Services

One initial indicator of project impact is the degree to which students engaged with services offered. When exiting a student from selective/intensive services, SAPs are instructed to record the level of student participation in their service plan in terms of attendance and effort. Of the 716 students who received full interventions in 2024-25, 688 had participation scores. As shown in Chart 8, **86% engaged** at a moderate-to-full participation level.

Chart 8 Level of Participation for Students with Full Intervention Services 2024-25

Student Satisfaction with Services

Another important metric for any direct service is recipient satisfaction. The post-survey administered after full interventions asks students three questions about their satisfaction with the program. 604 students responded to these items, representing 76% of all eligible students. As shown, **97%** reported that the program was **somewhat or very helpful** (Chart 9) and **96% were glad they participated** (Chart 10). Additionally, of the 359 students with low attendance before SAP services, **82%** reported being **more likely to attend** due to the program (Chart 11).

Chart 9 Satisfaction: Overall, how helpful has this program been to you?

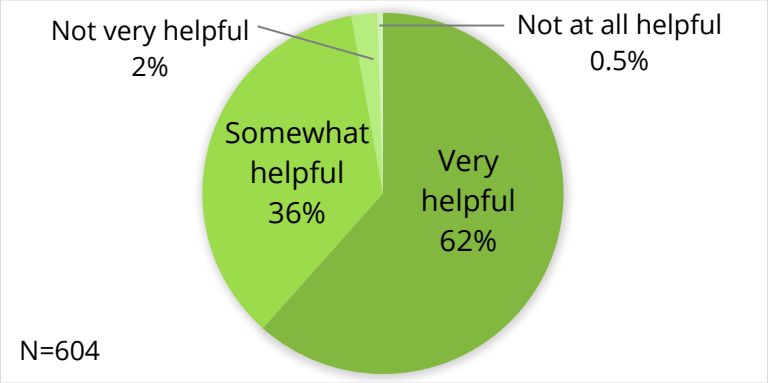


Chart 10 Satisfaction: Are you glad that you participated in the program?

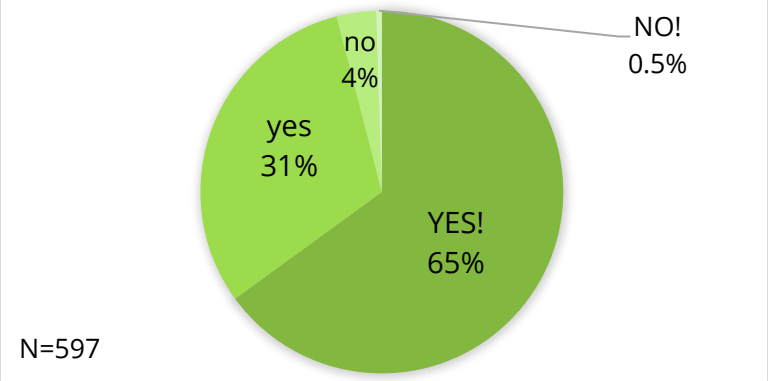
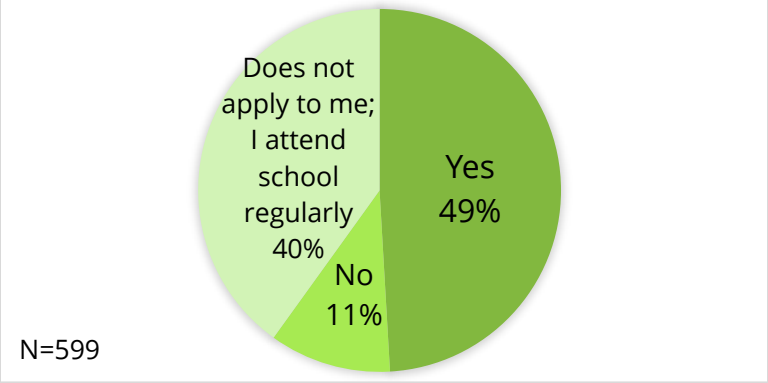


Chart 11 Satisfaction: Are you more likely to attend school because of this program?

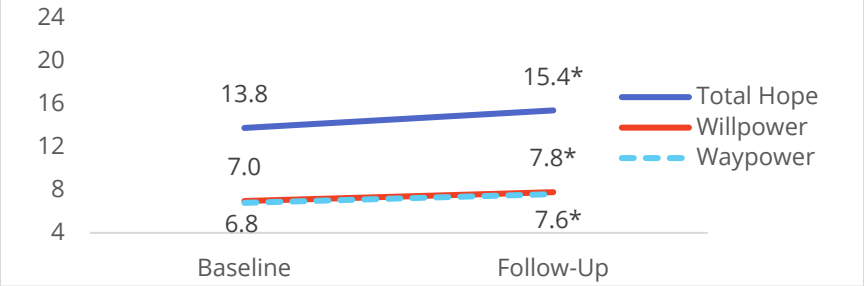


Increased Student Wellbeing

The primary measure of student wellbeing used in BH-SAP is the Children's Hope Scale (Snyder et al., 1997) which has been validated for youth aged 7 to 18 (Hellman et al., 2017). The scale consists of six questions, three which measure the child's agency or "willpower" and three which measure the child's pathway or "way power" to accomplishing their goals. In the 2022-25 student surveys, only four items from the hope scale were used (which was confirmed to be valid by the administrators of the WA Healthy Youth Survey in 2018).

Scoring: This measure uses a 6-point scale ranging from "none of the time" (with a value of 1) to "all of the time" (6). Adding items in the pathway and agency subscales will provide an overall hope score. The hope scores can then be interpreted using the following 4-band categorization system: scores of 4-8 indicate no to very low hope, 9-12 indicate slightly hopeful, 13-16 indicate moderately hopeful, and 17-24 indicate highly hopeful.

Chart 12 Average Student Hopefulness before and after Full Intervention Services 2024-25



Notes: N=625. Includes 6+ grade students receiving full BH-SAP interventions who were not missing more than 1 item from each Hope Subscale at baseline and follow-up. Asterisk (*) Indicates a significant change from pre to post (p-value <0.05).

As shown in Chart 12, paired sample t-tests concluded that at the time of the post-test, **students had significantly greater hope** (including significantly greater total score and subscale scores). Chart 13 displays the percentage of students in each hope category. At pre-test, about 57% of students were experiencing moderate-to-high hopefulness, compared to 75% at post. Finally, Chart 14 shows average scores for the hope scale items. Again, paired t-tests confirm there are significant improvements across all items at post.

Chart 13 Change in Student Hopefulness after Full Intervention Services 2024-25 (N=625)

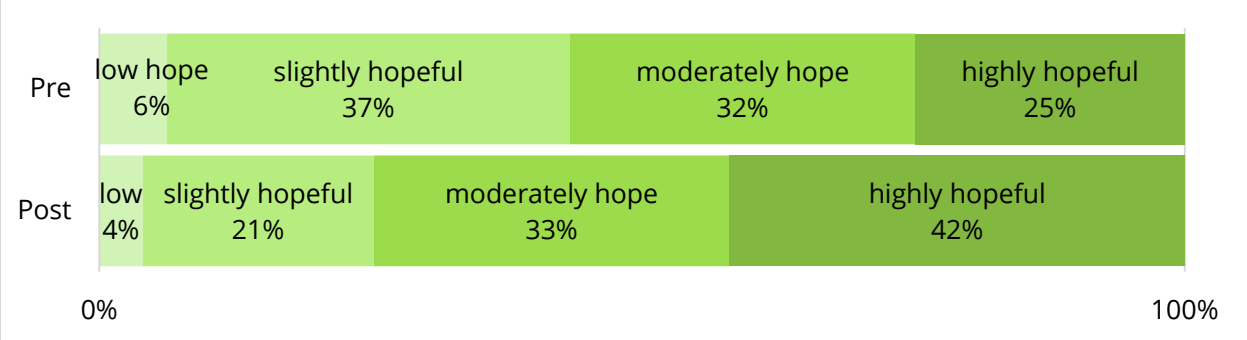
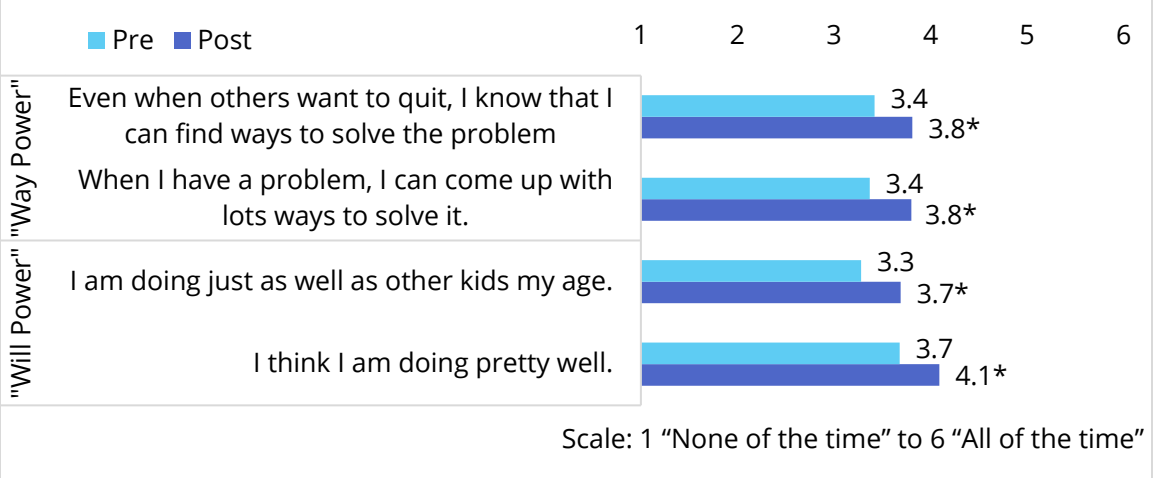


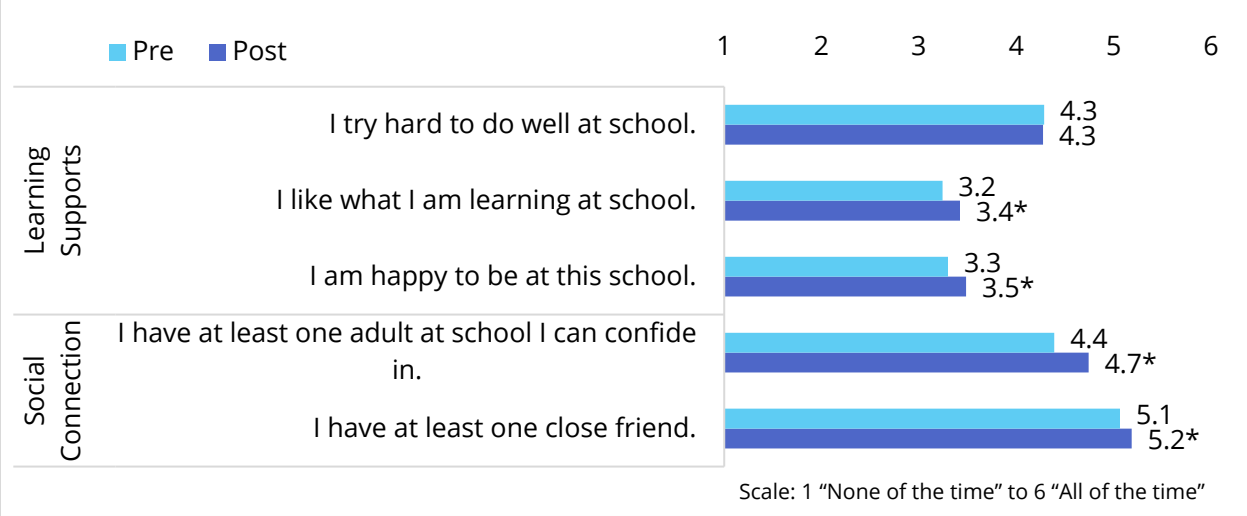
Chart 14 Average Student Hope Items before and after Full Intervention Services 2024-25



Notes: N=609-625. Includes 6+ grade students receiving full BH-SAP interventions missing no more than 1 item from each Hope Subscale at baseline and follow-up. Asterisk (*) Indicates a significant change from pre to post (p-value <0.05).

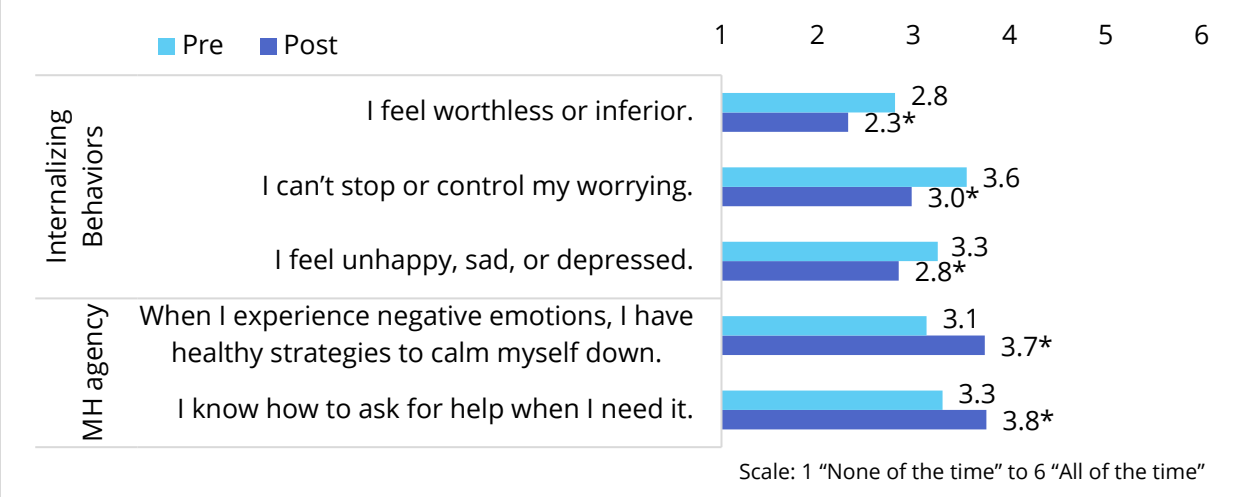
In addition to hopefulness, items capturing a wider range of student social, emotional, and behavioral (SEB) wellness indicators were added to the pre/post survey, beginning in the '22-23 school year. These include: Behavioral and Affective Learning items from the Student Engagement in Schools Questionnaire (SESQ; Hart et al., 2011), Social Connectedness items adapted from the Social Emotional Health Survey (SEHS; Furlong et al., 2018), Internalizing Behavior items from the Brief Problem Checklist (Chorpita et al., 2010), and MH Agency items developed by the UW Evaluation Team. Chart 15 and 16 display average scores on these items before and after students received intervention services. Paired sample t-tests were performed, and **significant improvements were found across most SEB wellness indicators**, except for one item ("I try hard to do well in school").

Chart 15 Social Connectedness and Learning Supports Average Ratings '24-25



Note. N varies from 613 to 626. Includes 6+ grade students receiving full BH-SAP interventions who completed each item at baseline and follow-up. Asterisk (*) Indicates a significant change from pre to post (p-value <0.05).

Chart 16 Mental Health Agency and Internalizing Behaviors Average Ratings '24-25



Note. N varies from 608 to 621. Includes 6+ grade students receiving full BH-SAP interventions who completed each item at baseline and follow-up. Asterisk (*) Indicates a significant change from pre to post (p-value <0.05).

Looking more deeply into the direction of change, a large portion of all students served reported elevated help-seeking and self-regulation skills. The largest improvements were: **51% gained healthy strategies to calm down** when experiencing negative emotions, **47% improved ability to ask for help** when needed, and **38% gained a trusted adult and increased their level of happiness while at school**. See Table 8 below for all cross-tabulations of the group-level changes from pre- to post-test.

Table 8 Changes to SEB Wellness Indicators for Student Groups '24-25

	SEB wellness indicator	Groups	Change from pre- to post-test, N (%)			Group Total
			Reduced	No Change	Increased	
Learning Supports	**Tries hard in school**	Students who started low	19 (11%)	53 (31%)	**101 (58%)**	173
		Students who started high	173 (39%)	159 (36%)	**108 (25%)**	440
		All Students	192 (31%)	212 (35%)	**209 (34%)**	613
	Likes learning at school	Students who started low	54 (14%)	133 (35%)	**190 (50%)**	377
		Students who started high	126 (51%)	79 (32%)	**41 (17%)**	246
		All Students	180 (29%)	212 (34%)	**231 (37%)**	623
	Happy at school	Students who started low	49 (13%)	132 (36%)	**187 (51%)**	368
		Students who started high	110 (43%)	97 (38%)	**48 (19%)**	255
		All Students	159 (26%)	229 (37%)	**235 (38%)**	623
Social Connectednes	**Has a trusted adult at school**	Students who started low	13 (7%)	37 (21%)	**130 (72%)**	180
		Students who started high	126 (29%)	202 (47%)	**105 (24%)**	433
		All Students	139 (23%)	239 (39%)	**235 (38%)**	613
	Has at least one close friend	Students who started low	5 (5%)	12 (13%)	**77 (82%)**	94
		Students who started high	125 (23%)	323 (61%)	**84 (16%)**	532
		All Students	130 (21%)	335 (54%)	**161 (26%)**	626
MH Agency	**Has coping strategies**	Students who started low	32 (8%)	110 (27%)	**271 (66%)**	413
		Students who started high	85 (41%)	75 (36%)	**48 (23%)**	208
		All Students	117 (19%)	185 (30%)	**319 (51%)**	621
	Knows how to ask for help	Students who started low	31 (8%)	115 (30%)	**243 (62%)**	389
		Students who started high	109 (48%)	75 (33%)	**44 (19%)**	228
		All Students	140 (23%)	190 (31%)	**287 (47%)**	617

Note. Includes 6+ grade students receiving full BH-SAP interventions who completed each item at baseline and follow-up. Students were separated into low (1: 'none' to 3: 'some') and high (4: 'a lot' to 6: 'all') based on pre-test scores.

There were also mental and emotional wellness improvements, with the greatest symptom reductions across all students being: **50% lowered anxiety symptoms** ("can't stop or control my worrying"), **44% lowered depression symptoms** ("feel unhappy, sad, or depressed"), and **43% increased self-worth** (reduced feeling "worthless or inferior"). See Table 9 below for all cross-tabulations of the group-level changes from pre- to post-test.

Table 9 Changes to Internalizing Symptoms for Student Groups '24-25

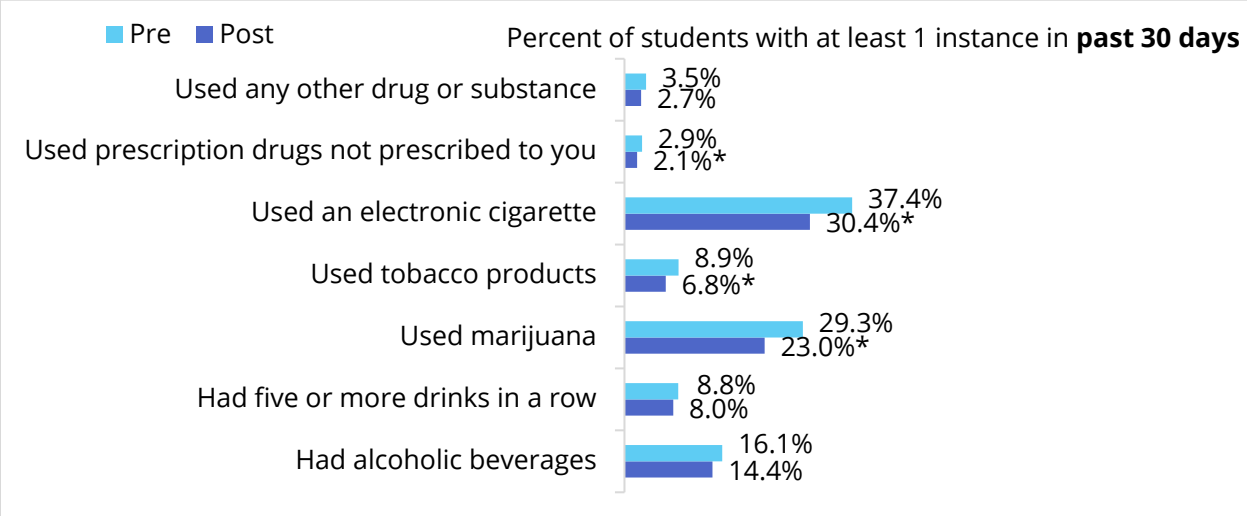
Internalizing symptom	Groups	Change from pre- to post-test N (%)			Group Total
		Reduced	No Change	Increased	
Unhappy, sad, or depressed	Students who started low	**98 (26%)**	174 (47%)	101 (27%)	373
	Students who started high	**172 (72%)**	42 (18%)	26 (11%)	240
	All Students	**270 (44%)**	216 (35%)	127 (21%)	613
Can't control worrying	Students who started low	**87 (28%)**	120 (39%)	102 (33%)	309
	Students who started high	**223 (72%)**	64 (21%)	23 (7%)	310
	All Students	**310 (50%)**	184 (30%)	125 (20%)	619
Feels worthless or inferior	Students who started low	**123 (29%)**	192 (45%)	107 (25%)	422
	Students who started high	**139 (75%)**	24 (13%)	23 (12%)	186
	All Students	**262 (43%)**	216 (36%)	130 (21%)	608

Note. Includes 6+ grade students receiving full BH-SAP interventions who completed each item at baseline and follow-up. Students were separated into low (1: 'none' to 3: 'some') and high (4: 'a lot' to 6: 'all') based on pre-test scores.

Decreased Substance Use

Substance use was measured with items revised from pre-existing SAP resources. Chart 17 displays the rate of students who used a substance at any point in the past 30 days. Students who received full BH-SAP intervention services reported **fewer instances of past month use across all substances**. Additionally, paired sample t-tests were performed, and **significant reductions were found for all substances except alcohol and other drugs** (e.g., amphetamines, barbiturates, inhalants, etc.).

Chart 17 Rates of Substance Use at Pre- and Post-Test '24-25



Note. N varies from 619 to 624. Includes 6+ grade students receiving full BH-SAP interventions who completed each item at baseline and follow-up. Asterisk (*) Indicates a significant change from pre to post (p-value <0.05).

When narrowing in on post-test usage of students who reported using substances at baseline, we find large reductions in the following areas: **83% decreased prescription misuse** (N=18), **75% decreased tobacco use** (N=55), **64% decreased drinking** (N=100), and **63% decreased marijuana use** (N=182). See Table 10 below for all cross-tabulations of the group-level changes from pre- to post-test.

Table 10 Changes to Substance Use for Student Groups '24-25

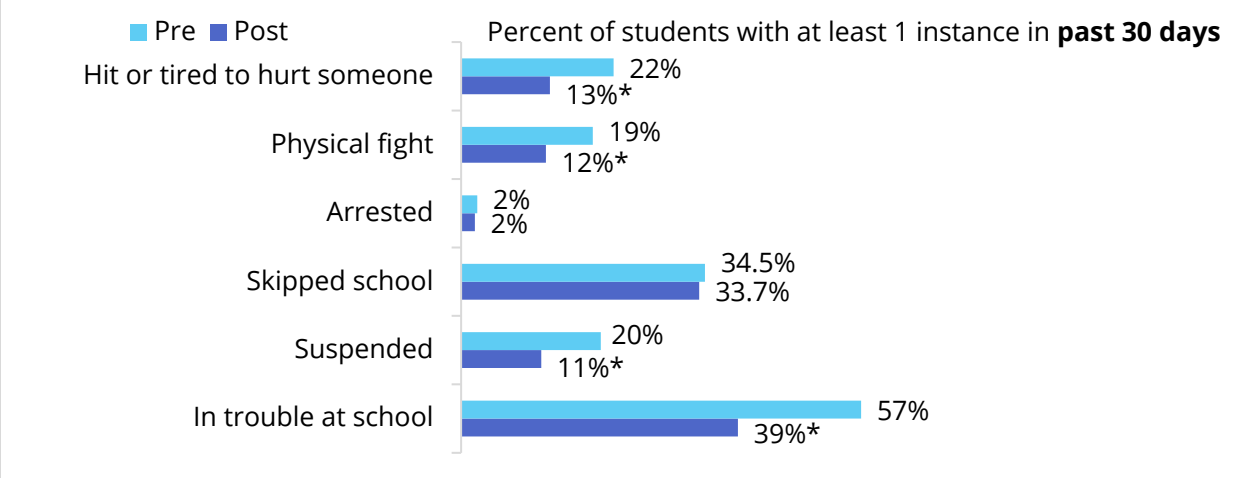
Substance use	Groups	Change from pre- to post-test N (%)			Group Total
		Reduced	No Change	Increased	
alcoholic beverages	Students not using at pre	**0 (0%)**	482 (92%)	41 (8%)	523
	Students using at pre	**64 (64%)**	28 (28%)	8 (8%)	100
	All Students	**64 (10%)**	510 (82%)	49 (8%)	623
five or more drinks in a row	Students not using at pre	**0 (0%)**	541 (95%)	28 (5%)	569
	Students using at pre	**35 (64%)**	18 (33%)	2 (4%)	55
	All Students	**35 (6%)**	559 (90%)	30 (5%)	624
marijuana	Students not using at pre	**0 (0%)**	411 (93%)	29 (7%)	440
	Students using at pre	**115 (63%)**	44 (24%)	23 (13%)	182
	All Students	**115 (18%)**	455 (73%)	52 (8%)	622
tobacco products	Students not using at pre	**0 (0%)**	546 (97%)	18 (3%)	564
	Students using at pre	**41 (75%)**	9 (16%)	5 (9%)	55
	All Students	**41 (7%)**	555 (90%)	23 (4%)	619
electronic cigarette	Students not using at pre	**0 (0%)**	356 (92%)	33 (8%)	389
	Students using at pre	**128 (55%)**	84 (36%)	20 (9%)	232
	All Students	**128 (21%)**	440 (71%)	53 (9%)	621
prescription drugs	Students not using at pre	**0 (0%)**	597 (99%)	8 (1%)	605
	Students using at pre	**15 (83%)**	3 (17%)	0 (0%)	18
	All Students	**15 (2%)**	600 (96%)	8 (1%)	623
any other drug or substance	Students not using at pre	**0 (0%)**	591 (99%)	9 (2%)	600
	Students using at pre	**14 (64%)**	7 (32%)	1 (5%)	22
	All Students	**14 (2%)**	598 (96%)	10 (2%)	622

Note. Includes 6+ grade students receiving full BH-SAP interventions who completed each item at baseline and follow-up.

Decreased Adverse Behaviors and Disciplinary Actions

The items used to gauge adverse behavior and disciplinary actions were also drawn from pre-existing SAP resources. As shown in Chart 18, students who received full BH-SAP intervention services reported **fewer instances of adverse behaviors and disciplinary actions** including: hitting or trying to hurt someone, getting into a physical fight, skipping school, getting suspended from school, and getting in trouble at school. Additionally, paired sample t-tests were performed, and **significant reductions were found for all categories apart from arrest and skipping school**.

Chart 18 Rates of Adverse Behaviors and Disciplinary Actions at Pre- and Post-Test '24-25



Note. N varies from 616 to 622. Includes 6+ grade students receiving full BH-SAP interventions who completed each item at baseline and follow-up. Asterisk (*) Indicates a significant change from pre to post (p-value <0.05).

Looking into post-test rates for students who reported instances of adverse behaviors at baseline, we find large reductions in the following areas: **79% decreased hitting/hurting others** (N=134), **77% decreased physical fighting** (N=115), **73% decreased suspensions** (N=122), and **61% decreased skipping school** (N=214). See Table 11 below for all cross-tabulations of the group-level changes from pre- to post-test.

Table 11 Changes to Adverse Behaviors and Disciplinary Actions for Student Groups '24-25

Adverse Behavior	Groups	Change from pre- to post-test N (%)			Group Total
		Reduced	No Change	Increased	
in trouble at school	Students with no instance at pre	**0 (0%)**	228 (84%)	42 (16%)	270
	Students with instance(s) at pre	**208 (59%)**	99 (28%)	44 (13%)	351
	All Students	**208 (33%)**	327 (53%)	86 (14%)	621
suspended from school	Students with no instance at pre	**0 (0%)**	468 (94%)	28 (6%)	496
	Students with instance(s) at pre	**89 (73%)**	25 (20%)	8 (7%)	122
	All Students	**89 (14%)**	493 (80%)	36 (6%)	618
skipped school	Students with no instance at pre	**0 (0%)**	323 (79%)	84 (21%)	407
	Students with instance(s) at pre	**131 (61%)**	42 (20%)	41 (19%)	214
	All Students	**131 (21%)**	365 (59%)	125 (20%)	621
arrested	Students with no instance at pre	**0 (0%)**	594 (99%)	8 (1%)	602
	Students with instance(s) at pre	**10 (71%)**	3 (21%)	1 (7%)	14
	All Students	**10 (2%)**	597 (97%)	9 (1%)	616
in a physical fight	Students with no instance at pre	**0 (0%)**	472 (94%)	31 (6%)	503
	Students with instance(s) at pre	**88 (77%)**	21 (18%)	6 (5%)	115
	All Students	**88 (14%)**	493 (80%)	37 (6%)	618
Hit or tried to hurt someone	Students with no instance at pre	**0 (0%)**	455 (93%)	33 (7%)	488
	Students with instance(s) at pre	**106 (79%)**	21 (16%)	7 (5%)	134
	All Students	**106 (17%)**	476 (77%)	40 (6%)	622

Note. Includes 6+ grade students receiving full BH-SAP interventions who completed each item at baseline and follow-up.

Region, District, and School-Level Impacts

Looking beyond the outcomes experienced by individual students, this section will describe how this project impacted the full school community, beginning with the results of the awareness and capacity building efforts and then by examining various aspects of school partner satisfaction with the program.

Increasing BH Awareness

Over the course of the 2024-25 school year, BH-SAP staff facilitated **145 behavioral health awareness events across 24 school buildings**. In addition, BH-SAP staff facilitated **255 Behavioral Health Leadership Club** meetings and taught important social-emotional and life skills through **263 evidence-based lessons**.

Capacity Building

To increase capacity among staff members in the schools they worked in, BH-SAP providers ensured staff were aware of behavioral health screening and referral processes and where appropriate, provided expertise in making accurate referrals. During the 2024-25 school year, BH-SAP staff provided **29 staff awareness presentations** and **326 screening and referral service sessions** with staff.

School Partner Satisfaction

"[The SAP's] influence has seen students dramatically improve and/or completely turn around their attendance, support [student] mental/emotional health, and collaborate with our Counseling team to coordinate care both on campus and off. [The SAP] is a known source for parents, students, and staff alike. With each group students attend, we in turn see an improvement in their ability to cope, make better decisions, and become more efficient learners. In addition, [the SAP] has spoken at staff meetings, coordinating presentation(s) with the Counseling department, and worked extensively with our coordinated care team. Because of the positive and intentional connecting between [the SAP] and the Counseling department and rest of the coordinated care team, we have built up a robust system of support that doesn't just stop when groups end. We are able to more effectively discuss with families systems of support that can be of benefit outside of school, make more effected referrals to programs like WISE or MST, or even more specific depending on the situation and student. All of these instances of tiered responses would not be as effective if it weren't for the intentional collaboration that we do with [the SAP]. Lastly, because of the groups that [the SAP] runs [and the] relationships built over the years, I can honestly say [on] at least 4 occasions, [the SAP has] been the reason why we have not had a student death from either overdosing or self-harm. [Their] impact has been huge, and truly, [I am] not able to put into words the value [the SAP] brings."

Project partners at participating, legislatively-funded school buildings were surveyed from March - June 2025 to gather input about the impact of the services provided by BH Student Assistance Professionals. **58 respondents completed the survey across all nine ESDs.**

As shown in Table 12, school partners largely agreed that the BH SAP services positively influenced school and classroom climate, positively impacted students' academic success and attendance, and increased students' ability to interact with peers and self-regulate. Additionally, **98%** of respondents found **services were helpful for students** (Table 13), **97%** believe their district/school **improved the ability to respond effectively** to students' behavioral health needs (Table 14), and **90%** stated that **having an SAP available was very important or of the highest importance** (Table 15).

School partners were also invited to share open-ended comments in response to the following prompts: "Please provide an example to illustrate or explain the answers you provided above" and "Please provide any and all recommendations on how this program can be improved in the future." Responses from all legislatively-funded sites were coded into qualitative themes which are reported in Table 16. The majority of illustrative examples shared reinforced the following themes: SAPs are trusted adults who respond quickly to student needs, provide prevention and SEL supports that strengthen student coping skills, strengthen MTSS and school-based support teams, effectively fill a gap in essential school services, and reduce substance use and provide targeted prevention. In terms of program improvements, the most common requests were around program continuation or expansion needs, operational improvements, funding and financial support, additional staffing / lower caseloads, consistent staffing, and the need for more data & feedback.

Table 12 School Partner Ratings of Program Impact for Participating Students

Prompts	**Responses**						**Summary**
Services provided through this project have:	Strongly Disagree	Disagree	No Change	Agree	Strongly Agree	Total	*Agree & Strongly Agree*
Increased students' ability to self-regulate	2 (3.5%)	0 (0.0%)	3 (5.2%)	23 (39.7%)	30 (51.7%)	58 (100%)	53 (**91%**)
Increased students' social skills/ability to interact with peers	2 (3.5%)	0 (0.0%)	3 (5.2%)	23 (39.7%)	30 (51.7%)	58 (100%)	53 (**91%**)
Positively impacted students' attendance	3 (5.4%)	0 (0.0%)	5 (8.9%)	22 (39.3%)	26 (46.4%)	56 (100%)	48 (**86%**)
Improved students' academic success	2 (3.5%)	1 (1.8%)	3 (5.3%)	27 (47.4%)	24 (42.1%)	57 (100%)	51 (**89%**)
Positively influenced classroom climate	2 (3.5%)	2 (3.5%)	2 (3.5%)	20 (34.5%)	32 (55.2%)	58 (100%)	52 (**90%**)
Positively influenced the school climate	2 (3.5%)	2 (3.5%)	2 (3.5%)	16 (27.6%)	36 (62.1%)	58 (100%)	52 (**90%**)

Table 13 School Partner Ratings of Program Helpfulness

Overall, how helpful do you feel the project's services have been for participating students?			
Answer	**Count**	**%**	***Category Totals***
Harmful or negative	0	0%	***Not Helpful: 1 (2%)***
Made no difference	1	2%	
Somewhat helpful	13	22%	***Helpful: 57 (98%)***
Very helpful	44	76%	
Total	**102**	**100%**	

Table 14 School Partner Ratings of Program Impact to School/District BH Response

Do you believe your district/school has experienced improvements in its ability to respond effectively to students' behavioral health needs because of this program?			
Answer	**Count**	**%**	***Category Totals***
No, not at all	1	2%	***No Improvement: 2 (3%)***
No, not much	1	2%	
Yes, somewhat	16	28%	***Improvement: 56 (97%)***
Yes, substantially	40	69%	
Total	**101**	**100%**	

Table 15 School Partner Ratings of Program Importance

How important is it to have a Student Assistance Professional available in your school?			
Answer	**Count**	**%**	***Category Totals***
Not at all important	0	0	***Not very important: 6 (10%)***
Not very important	1	2%	
Somewhat important	5	9%	
Very important	14	24%	***Very important: 52 (90%)***
Of the highest importance	38	66%	
Total	**102**	**100%**	

Table 16 Qualitative themes and representative quotes from school partners '24-25

Program Strengths and Impacts		Count
SAPs are trusted adults who respond quickly to student needs	*Our SAP builds positive relationships with students and uses these relationships to encourage students, coordinate support for students, and increase student success*	**21**
SAPs provide prevention and SEL supports that strengthen student coping skills	*[Our SAP] has taught many middle school students coping strategies when feeling anxious in class. [They] also help promote self care and kindness campaigns throughout the middle and high school which has enhanced a positive culture at our schools.*	**15**
SAPs strengthen MTSS and school-based support teams	*Our SAP is an integral part of our counseling team and behavioral MTSS. They are on our Student Support Team, mentor students, run groups and individual meetings, contact parents, join other team meetings to advocate for students, and connect students from and to other school supports…*	**14**

SAPs effectively fill a gap in essential school services	*It took me a while to come up with the words to share with you adequately how much [the SAP] has meant to us at [school name]… Through the course of having a SAP in the building, we have been able to stabilize our counseling/resource staff. Currently students know they have a trusted adult and can now self-advocate.*	**11**
SAPs reduce substance use and provide targeted prevention	*The SAP does some great preventative work with our entire school, has created a great climate within the school club and finds ways to use student voice to improve students emotional and refusal of use resilience. The program has been life changing for a few students that need the specific support and then extremely impactful to spread messaging and connect all students to support and the vision that substance use does not need to be a part of their daily lives.*	**10**
Program Challenges and Recommendations for Improvement		**Count**
Program continuation and/or expansion needs	*I think every district should have at least one SAP for intermediate and secondary levels! It would be nice to be able to have part-time help for students transitioning from elementary to intermediate levels when there is an uptick in experimentation among peers.*	**18**
Operational improvements	*Please, if a teacher requests that a student stay in class for their lesson do not ask to discuss the matter on the spot… Also I suggest working with students on returning to class without disrupting (quietly walking back to class, entering, and getting started on the task).*	**11**
Funding and financial support	*Consistent funding for this position is essential to our ability to implement the program effectively, as it is difficult to plan for the next year when we don't know if we will have the position.*	**5**
Additional staffing / lower caseloads	*If we had another staff member, that would be so incredible. We have so many students in need of the programming but not enough time in the year and [the SAP] does not have enough space in her groups to meet the need of our building.*	**4**
Consistent staffing / more days per week	*It would be great to have the program 5 days a week.*	**3**
Need more data & feedback	*Maybe we can receive brief feedback about how this is helping these specific kids at their next level/future and beyond.*	**3**

Discussion

Findings

As reflected by the results reported above, with a network of 18 Student Assistance Professionals working across 9 ESDs and 24 school buildings, the BH-SAP contributes meaningfully to Washington's goal for building a statewide student behavioral health support system.

- Beginning with federal funds that were then supplanted by a relatively modest allocation of state funds, Washington was able to invest in 18 SAPs serving all 9 ESDs and 24 schools. These SAPs intervened with over 837 students directly while also providing over 14,000 students with school-wide prevention activities. Moreover, these students largely reflected the diversity of Washington's students overall.
- **The BH-SAP program allowed local districts to provide critical BH services that would otherwise be difficult for an LEA to provide**, such as prevention activities (145 student awareness events) that are essential components of a multi-tiered BH system. Furthermore, SAPs provided screening to 721 students and participated in referral services as part of a multidisciplinary team on 326 occasions, activities required by RCW 28A.320.127 but inconsistently provided by Washington LEAs.
- **Outcomes data collected found that SAPs effectively identified and served students** who started the school year experiencing concerns such as elevated behavioral health symptoms, substance use, and poor school attendance. Students ended the year with higher levels of hope, improved social-emotional-behavioral wellness, and fewer adverse behaviors and disciplinary problems.
- **SAP program services were rated highly among participating students and school staff members alike.** Ninety-seven percent of students said the program was helpful, and 98% of district partners reported that the BH-SAP program was a critically important component of their local system of BH supports.

Limitations

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

A second limitation relates to human error and individual interpretation in documentation. The reporting of certain data items, such as universal prevention activities, requires the SAPs to translate their experience of events into a fixed set of options in the data reporting system. This need for translation can result in inconsistencies in how staff across the state code their activities and impact the precision of specific staff-documented data elements. As a part of continued efforts towards state-wide alignment of services and documentation, the project released and provided training on a new data documentation

manual in the fall of 2023. Regular data reviews based on these clarified guidelines have also supported consistent documentation and cleaner data for future analysis.

A third limitation relates to the short timeframe for data collection (from program intake to program exit or the end of the school year). Outcome is currently tracked for full intervention students (those receiving at least 3 contacts with a student assistance professional). These data provide a limited picture of a school success outcome, but longer-term outcome data are not available.

A fourth limitation affecting interpretation of outcome findings is the lack of a comparison group. Programs for at-risk students are typically hard-pressed to find and survey a comparable sample of students who are identified as at risk but not offered services. Nevertheless, the lack of a comparison condition restricts the ability to unequivocally conclude that observed changes in outcomes were directly associated with the program. To address this limitation, the evaluation team successfully requesting previous Healthy Youth Survey (HYS) records (from 2010 to 2023) to compare relevant items and scales for students attending schools/districts receiving BH-SAP services versus those at comparison schools/districts matched on community and student demographic characteristics.

Finally, a concern in any evaluation is understanding the impact of survey attrition. While Student Assistance Professionals attempt to administer post-tests with all full intervention students in 6 grade and above, regardless of whether they complete the program, students may transfer out of the school, refuse survey participation, or become unavailable for other reasons. As shown in Table 17, in the '24-25 school year, there were 716 total eligible students. 692 were pre-tested, 634 were post-tested, and 634 were both pre- and post-tested. From that group, 626 students with both tests had completed at least 1 test item for both time points (meaning they did not submit a blank test). Of the 58 students missing a post-test, 46 have a reason recorded for why it was not administered. The top reasons were that the student moved/transferred schools (52%), the student dropped out (13%), the SAP was unable to locate the student (11%), or the student refused to participate (9%).

Table 17 Pre-Post Evaluation Counts for Eligible Students '24-25

Eligible students	Pre-tested	Post-tested	Matched tests	Data Submitted for both Pre and Post-tests
716	692 (97%)	634 (89%)	634 (89%)	626 (87%)

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Appendix

AESD Statewide Behavioral Health Student Assistance Program Adherence Evaluation Plan (Updated 3/20/24)

Student Assistance Professional Role and Responsibilities

Each SAP position is required to be a minimum of 180 days, assigned to the approved AESD Site. These positions are intended to be non-licensed positions and are *only funded to provide prevention and interventions services for substance abuse and mental health*. This is critical because treatment services are funded through other State and Federal dollars. Any treatment services should be referred out to a licensed provider or billed to MCO's or private insurance payors.

Program Component and supporting evidence	Indicator(s) of fidelity to the component, with operational definitions	Data sources to be used to evaluate adherence to each component/ indicator (Primary Sources: ***LGAN Service Data, ESD fidelity and staffing checklist, Building Partner Survey***)
State-wide Project Engagement		
Each SAP position is required to be a **minimum of 180 days**, assigned to the approved AESD Site.[1]	<u>For staff split across programs:</u> Staff 100% FTE through BH SAP project 180 days at 8 hrs./day OR 260 days at 6 hrs./day (may be co-funded for 2 hrs./day) <u>For staff split across buildings:</u> SAP to Student Ratio should not exceed 1,000 Students	*ESD fidelity and staffing checklist:* • Is the position at least 180 days? (Y/N) • Year staff started with program • School(s) Served for BH SAP Program: School Name, District, First year of participation, Staff FTE at school *WA State School Report Card:* • Student enrollment for current school year
Attend all required SAP trainings including the Back to School series and specific intervention training as required for project implementation as well as any	Staff attend (or have approved absence for) 100% of training events	*ESD fidelity and staffing checklist:* • So far this year, this staff member has attended all program-required trainings (Y/N, N/A – if staff started partway through the year or had approved absence).

[1] Schutte, K., Maike, M. M., Johnson, M. M., & Grunenfelder (2012). Washington's Student Assistance Prevention-Intervention Services Program: Program Manual. Olympia, WA: Office of Superintendent of Public Instruction. https://ospi.k12.wa.us/sites/default/files/2022-12/sapispmanual2012.pdf

Program Component and supporting evidence	Indicator(s) of fidelity to the component, with operational definitions	Data sources to be used to evaluate adherence to each component/ indicator (Primary Sources: ***LGAN Service Data*, *ESD fidelity and staffing checklist*, *Building Partner Survey***)
emergent trainings identified by the project[2]		*ESD 113 team will have zoom participant list as they hosted September trainings*
Participate in all required project meetings, including TRAILS monthly consultation and fidelity calls[3]	Staff attend 100% of project meetings Staff attend 80% of monthly consultation and fidelity calls	*ESD fidelity and staffing checklist:* • So far this year, this staff member has Participated in all program-required meetings (Y/N/n/a – if staff started partway through the year or had approved absence) *TRAILS monthly call attendance record will also be reviewed to confirm this information*
Prevention and Intervention Services for mental health and substance abuse		
Participate in school building staff meetings for the purpose of promoting the program and informing staff on access to services and the referral process. Assisting staff in understanding signs and symptoms of mental health and substance abuse concerns in students.[4]	Staff will have attended at minimum, 1 meeting at each school per academic quarter (3 per year)	*ESD fidelity and staffing checklist:* • So far this year, this staff member has Participated in school building staff meetings to promote the program and share information on how to make referrals and access services *LGAN Activity Data [School Code, Date, N Participants, N Hours, N Sessions]:* • Staff awareness presentation (primary code), may review Information dissemination to staff (secondary code)
Conduct classroom presentations on the topics of mental health and substance use	Staff will present a minimum of 1 substance abuse and 1 mental health	*ESD fidelity and staffing checklist:*

[2] Markle, B., Splett, J. W., Maras, M. A., & Weston, K. J. (2014). Effective school teams: Benefits, barriers, and best practices. In M. D. Weist, N. Lever, C. Bradshaw & J. Owens (Eds.), Handbook of school mental health: Research, training, practice, and policy (2nd ed.). New York: Springer.
[3] Schoenwald, S. K., Sheidow, A. J., & Letourneau, E. J. (2004). Toward effective quality assurance in evidence-based practice: Links between expert consultation, therapist fidelity, and child outcomes. Journal of Clinical Child & Adolescent Psychology, 33(1), 94–104.
[4] Connors, E., Lever, N., & Hoover, S. (2021). Alignment of School Mental Health Quality Frameworks and Tools: Guidance to the Field. Baltimore, Maryland: National Center for School Mental Health

Program Component and supporting evidence	Indicator(s) of fidelity to the component, with operational definitions	Data sources to be used to evaluate adherence to each component/ indicator (Primary Sources: ***LGAN Service Data, ESD fidelity and staffing checklist, Building Partner Survey***)
as indicated by the project. (Each site should select a minimum of 1 substance abuse and 1 mental health presentation to conduct.) • TRAILS identified SEL- (finalizing sessions for year 3)[5] • Substance Abuse Prevention Ed Series • Stress, Anxiety, and Coping Skills[6] • Vape Education	presentation to conduct within a student grade band/class type, as identified by school MDT/admin	• So far this year, this staff member has Conducted classroom presentations on the topics of mental health and substance use [checkbox with 4 options: 1) Substance Abuse Prevention Ed. Series, 2) Stress, Anxiety, and Coping Skills, 3) Vape Education, and 4) Other *LGAN Activity Data [School Code, Date, N Participants, N Hours, N Sessions]:* • Prevention Education Series & Presentation about BH issues, Second Step, Other Curriculum (e.g., Character Strong)
Coordinate and implement quarterly Universal Prevention campaigns associated with the project as identified and directed by project leads: 1) Suicide Prevention (RUOK, Seize the Awkward) 2) Bullying Prevention/Unity Day 3) Substance Use Prevention 4) Mental Wellness	Staff will conduct at minimum, 1 day of Behavioral health awareness event activities for each identified campaign (4 total)	*ESD fidelity and staffing checklist:* • So far this year, this staff member has Implemented Universal Prevention Campaigns [list names] *LGAN Activity Data [School Code, Date, N Participants, N Hours, N Sessions]:* • Behavioral health awareness event
Participate in multidisciplinary team at school location (i.e. Core Team, Student Support Team, Care Team, Tier 2 Team,	Staff will participate in multidisciplinary team meeting monthly, at minimum	*ESD fidelity and staffing checklist:* • So far this year, this staff member has Participated in school multidisciplinary team meetings to facilitate referrals and coordinate supports (Y/N) *LGAN Activity Data [School Code, Date, N Participants, N Hours, N Sessions]:*

[5] Rodriguez-Quintana, N. Evaluation of the impact of the Tier 1 SEL program in Michigan. Manuscript in preparation (Ann Arbor, MI: TRAILS to Wellness)

[6] Perry, Y., Petrie, K., Buckley, H., Cavanagh, L., Clarke, D., Winslade, M., … & Christensen, H. (2014). Effects of a classroom-based educational resource on adolescent mental health literacy: A cluster randomised controlled trial. Journal of Adolescence, 37, 1143–1151.

Program Component and supporting evidence	Indicator(s) of fidelity to the component, with operational definitions	Data sources to be used to evaluate adherence to each component/ indicator (Primary Sources: ***LGAN Service Data*, *ESD fidelity and staffing checklist, Building Partner Survey***)
etc.) to facilitate referral and coordination of supports[7] [8]		• Screening and Referral Services
Conduct screening[9], interventions and referrals for students based on need, including coordination and follow up with outside resources as needed	Staff have 100% of "Quick and full" intervention students screened If "care coordination" is checked as service, Minimum .25 hours of care coordination and minimum of 1 other referral-related service logged (e.g., assist with treatment arrangements, support during treatment, consult with school staff) Every Full student has attendance in at least one Group / 1x1 service	*ESD fidelity and staffing checklist:* • So far this year, this staff member has Conducted screening, interventions and referrals for students *LGAN Student Data:* • Intervention and Other Direct Services [Checklist]: BH screening, BH family conference, Assist with treatment arrangements, Support during treatment, Coordinate re-entry care, Provide info. or ref. to family, Obtain consent, Conference/Meet with parent, Family Counseling, Family prevention/education, Student declined release, Behavior contract, Individual services/counseling, Group services/counseling, Consult with school staff, Peer helper/mentor, Care Coordination • Case management referrals to other school/community resources [0"not referred" 1"referred, no followup" 2"did not attend" 3"attended" 4"completed" 5"service not accessible" 6"already receiving this service" 7"services not geographically available"]: AOD assessment, AOD counseling, AOD in-patient, AOD out-patient, childcare, child protective services, community

[7] Nancy Lever & Sharon Hoover (2023) Evaluating Strategies to Promote Effective, Multidisciplinary Team Collaboration in School Mental Health, Journal of Applied School Psychology, 39:2, 130-150, DOI: 10.1080/15377903.2022.2077875

[8] Reaves, S., Bohnenkamp, J., Mayworm, A., Sullivan, M., Connors, E., Lever, N. Bruns, E.J., ... & Hoover, S. (2022). Associations between school mental health team membership and impact on service provision. School Mental Health, 14(3), 672-684.

[9] Substance Abuse and Mental Health Services Administration: Ready, Set, Go, Review: Screening for Behavioral Health Risk in Schools. Rockville, MD: Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration, 2019. https://www.samhsa.gov/sites/default/files/ready-set-go-review-mh-screening-schools.pdf

Program Component and supporting evidence	Indicator(s) of fidelity to the component, with operational definitions	Data sources to be used to evaluate adherence to each component/ indicator (Primary Sources: ***LGAN Service Data***, ***ESD fidelity and staffing checklist, Building Partner Survey***)
		support group, employment/vocational, family worker, living arrangements, medical/financial assistance, mental health care, physical health care, police/juvenile justice, school counselor, transportation, other
Implement individual and group[10] Intervention curriculum as directed by the project, including but not limited to: • Mental Health Intervention Curriculum ○ Trails-Coping Curriculum (**required at all sites**)[11] [12] • Substance Abuse Intervention Curriculum ○ ATOD Education ○ Intervention/Abusers SUD (i.e. Teen Intervene) ○ Affected Others/COSAPs • Other emergent models (i.e. Brief Intervention, Recovery Support, SMART model, etc.)[13]	Requirement: Each staff will conduct at least 1 TRAILS group and at least 1 SUD group (SUD requirement for middle school and higher only)	*ESD fidelity and staffing checklist:* • So far this year, this staff member has Conducted **Mental Health** Interventions: Group, Individual, Both • So far this year, this staff member has Conducted **Substance Use** Interventions: Group, Individual, Both *LGAN Group Data [N Groups, N Students Enrolled, N Sessions]:* • ATOD Education • Intervention/ Abusers • Affected Others/ COSAPs • Social Skills/ Nonusers • Recovery • Other support group • TRAILS – Coping with COVID *LGAN Student Data:* Groups 1x1 listed

[10] Lochman, J. E., Dishion, T. J., Powell, N. P., Boxmeyer, C. L., Qu, L., & Sallee, M. (2015). Evidence-based preventive intervention for preadolescent aggressive children: One-year outcomes following randomization to group versus individual delivery. *Journal of consulting and clinical psychology*, *83*(4), 728–735. https://doi.org/10.1037/ccp0000030

[11] Bilek, E., Tomlinson, R. C., Whiteman, A. S., Johnson, T. D., Benedict, C., Phan, K. L., Monk, C. S., & Fitzgerald, K. D. (2022). Exposure-Focused CBT Outperforms Relaxation-Based Control in an RCT of Treatment for Child and Adolescent Anxiety. Journal of Clinical Child and Adolescent Psychology: The Official Journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53, 51(4), 410–418. https://doi.org/10.1080/15374416.2021.1901230

[12] Smith, S.N., Almirall, D., Choi, S.Y. et al. Primary aim results of a clustered SMART for developing a school-level, adaptive implementation strategy to support CBT delivery at high schools in Michigan. Implementation Sci 17, 42 (2022). https://doi.org/10.1186/s13012-022-01211-w

[13] Bruns, E.J., Lee, K., Davis, C. et al. Effectiveness of a Brief Engagement, Problem-Solving, and Triage Strategy for High School Students: Results of a Randomized Study. Prev Sci 24, 701–714 (2023). https://doi.org/10.1007/s11121-022-01463-4

Program Component and supporting evidence	Indicator(s) of fidelity to the component, with operational definitions	Data sources to be used to evaluate adherence to each component/ indicator (Primary Sources: ***LGAN Service Data, ESD fidelity and staffing checklist, Building Partner Survey***)
Facilitate or partner with Youth Prevention Club[14] to coordinate activities for the school community	Youth Prevention/Leadership clubs meet monthly (minimum of 8 meetings per year)	*ESD fidelity and staffing checklist:* • So far this year, this staff member has Facilitated or partnered with youth prevention/ leadership club [Y/N] *LGAN Activity Data [School Code, Date, N Participants, N Hours, N Sessions]:* • Behavioral Health Leadership Clubs
Provide or support parent[15][16] **and/or community training** specific to substance abuse and mental health topics. These trainings can be offered in collaboration with other projects with the SAP promoting and attending to engage with parent and community members. May include: SUD Prevention: Parent Night Out, Vape Education Mental Health Promotion/Suicide Prevention: Stress, Anxiety, and Coping Skills, QPR, YMHFA	Provide or support parent and/or community training twice per year, at minimum	*ESD fidelity and staffing checklist:* • So far this year, this staff member has Conducted or Supported Family and/or Community Presentations *LGAN Activity Data [School Code, Date, N Participants, N Hours, N Sessions]:* • Community presentation • Awareness presentations to parents
Data Collection and Reporting		
Enter all appropriate project data into LGAN system and maintain throughout the school year[17]	LGAN data updated at least weekly All Universal Prevention activities: entered in the system	*LGAN Student Data, Activity Data, & Group Data* all verified by reported activities in *ESD fidelity and staffing checklist*

[14] O'Malley, M., Wolf-Prusan, L. New Approaches to Youth Violence Prevention in Schools Issue Brief. Developed under contract number HHSS283201200030I for the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA). Retrieved from https://dm0gz550769cd.cloudfront.net/shape/b0/b046aca50dec3740a54ed60119400e7c.pdf.

[15] Ballard-Krishnan, S. A., McClure, L., Schmatz, B., Travnikar, B., Friedrich, G., & Nolan, M. (2003). The Michigan PBS Initiative: Advancing the Spirit of Collaboration by Including Parents in the Delivery of Personnel Development Opportunities. Journal of Positive Behavior Interventions, 5(2), 122-126. https://doi.org/10.1177/10983007030050020701

[16] Rones, M., Hoagwood, K. School-Based Mental Health Services: A Research Review. *Clin Child Fam Psychol Rev* **3**, 223–241 (2000). https://doi.org/10.1023/A:1026425104386

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

Program Component and supporting evidence	Indicator(s) of fidelity to the component, with operational definitions	Data sources to be used to evaluate adherence to each component/ indicator (Primary Sources: ***LGAN Service Data, ESD fidelity and staffing checklist, Building Partner Survey***)
	All Students Records: Intake, Screening, Services, Referral, and Exit tabs completed All Full intervention Student Records: Entered with associated intervention goals, Completion of pre/post-tests	
Assist with other data collection efforts as requested by the project or evaluator	Building Partner Survey completed by 1 staff member per building, at minimum	*Building Partner Survey*

Regional Behavioral Health Coordinator Role and Responsibilities

Each coordinator position is required to be a minimum of 260 days. These positions are intended to provide project oversight, ensuring engagement with other initiatives, quality program implementation, and timely data collection.

Program Component and supporting evidence	Indicator(s) of fidelity to the component, with operational definitions	Data sources to be used to evaluate adherence to each component/ indicator (Primary Sources: ***LGAN Service Data, ESD fidelity and staffing checklist, Building Partner Survey***)
Engagement and Collaboration		
Attend all required project meetings, including monthly Coordinator calls	Coordinator attends (or has approved absence for) 100% of project meetings	*Monthly coordinator meeting attendance – ESD 113 team will have these as they are hosting zoom*
Engage with other regional behavioral health programs including behavioral health navigation, MTSS, threat assessment and school safety within the region		
Promote access to behavioral health consultation and resource supports to local districts and schools		
Student Assistance Professional (SAP) and Program Oversight		

Implement Student Assistance Programs at identified program sites as described above		
Coordinate and engage with district leaders from SAP sites to ensure awareness of program goals and to facilitate a collaborative implementation of Tier 1 and Tier 2 services		
Oversee and supervise SAPs[18], including support for hiring, filling, and onboarding of SAP positions		
Facilitate and coordinate professional development, as needed		
Ensure staff compliance with all program requirements, including those listed in the Student Assistance Professional role and responsibilities description above		
Data Collection Quality Assurance		
Train Student Assistance Professionals on data collection in the LGAN system including student entry, pre and post evaluation collection, group tracking and prevention activity documentation		
Monitor data quality using available LGAN reports and work with staff to correct data when necessary[19][20]	Review Prevention Activity Data Verification Reports	*LGAN Prevention Activity Data* - Any data which has been flagged for correction will be corrected in LGAN within 1 month of receipt
Assist with other data collection efforts as requested by the project or evaluator	Building Partner Survey completed by 1 administrator per building, at minimum	*Building Partner Survey*

[18] Linda Dusenbury, Rosalind Brannigan, Mathea Falco, William B. Hansen, A review of research on fidelity of implementation: implications for drug abuse prevention in school settings, *Health Education Research*, Volume 18, Issue 2, April 2003, Pages 237–256, https://doi.org/10.1093/her/18.2.237

[19] PHII (March 19, 2024) Summary of Laws Related to Child and Adolescent Mental Health. Retrieved from https://phii.org/resources/summary-of-laws-related-to-child-and-adolescent-mental-health/.

[20] National Center on Response to Intervention, & American Institutes for Research (AIR). (2013). Brief #4: Ensuring Fidelity of Assessment and Data Entry Procedures. Screening Briefs Series. In *National Center on Response to Intervention*. Available at https://eric.ed.gov/?id=ED594238.