Vermont School-Based Substance Abuse Services

Summary of Published Guidelines and Recent Studies Regarding School-based Screening for Substance Use and Mental Health Issues (Middle Schools and High Schools)

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Prepared by:

Pacific Institute for Research and Evaluation

PIRE

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Please contact Amy Livingston at 802-652-4111, or alivingston@pire.org, if you have questions regarding this report or would like further information.

Introduction

All Supervisory Unions (SUs) receiving ADAP's SBSAS funds are required to deliver screening and referral for possible substance use and/or mental health issues using either the CRAFFT or GAIN Short Screener evidence-based screening tools. These screening and referral services are essential components of a comprehensive school-based substance abuse prevention program and align with the Counseling, Psychological, and Social Services component of the CDC's Whole School, Whole Child, Whole Community framework which is promoted by VDH and the Vermont Agency of Education (https://www.cdc.gov/healthyschools/wscc/components.htm). School-based screenings are intended to identify students who could benefit from early intervention services, including additional assessment and either brief intervention or other clinical services from a school or community-based clinician if needed. ADAP tracks the percent of those students who screen positive for substance use disorders that are referred for additional services as a performance measure on the VDH Performance Scorecard (http://www.healthvermont.gov/scorecard-alcohol-drugs).

ADAP provided training on using these screening tools at the beginning of the FY17-19 funding cycle and expected SUs to develop or update their screening protocols and work with local treatment providers to update referral protocols as needed to help ensure successful referral to services, and then distribute these protocols to school staff and train them on their use. Based on data submitted to ADAP during the 2017-18 school year, all 20 funded SUs have Student Assistance Professionals (SAPs) providing screenings. In addition to SAPs, several SUs also have school-based clinicians, guidance counselors and/or school nurses who also sometimes providing screenings.

So far, SBSAS-funded SUs have used "selective screening" practices, in which students are primarily selected for screening by teachers, peers, or parents who are concerned about a student or because the student has violated the school's alcohol and drug policies. Ten of the 20 funded SUs are using the CRAFFT screener, four use the GAIN-SS and six use a combination of both tools. Two SUs from the group that uses a combination of CRAFFT and GAIN-SS also report using the Massachusetts Youth Screening Instrument (MAYSI). Students who screen positive for either substance use or mental health issues according to these screening tools are then referred for a more thorough assessment and other services as needed. Additionally, based on data reported by the participating SUs, it appears that students are sometimes referred directly for clinical assessment and other services without necessarily being identified through one of the screening tools. In such cases, these students are still counted as "screening positive."

At the end of the 2014-15 school year, funded SUs were asked to identify barriers to students getting screened. One of the most frequently cited barriers was students not being identified by staff as having a potential problem. Other barriers mentioned include student resistance or refusal, time constraints, lack of parental support, stigma and confidentiality concerns. During the current funding cycle, grantees report that they have been improving and sharing internal screening and referral protocols with teachers and staff, in hopes of helping address these barriers.

Data collected from grantees for the 2017-18 school year (see Attachment A) show that the percent of students screened using either the CRAFFT or GAIN-SS (or both) ranged across SUs from 1 to 26% of students in grades 6-12. The overall rate was 6%, and the majority of SUs screened fewer than 10% of 6-12th grade students. The variability in screening rates across SUs suggests that a wide variety of approaches and criteria has been used by the grantees to select students for screening with the required screening tools. It is likely that SUs with low screening rates relied more heavily on other information to identify students needing assessment and other services (i.e., as an alternative mechanism for identifying "positive screens").

No currently funded SUs reported screening all students (for either the entire school or a selected grade level) using a designated screening tool during the past school year. Yet universal screening, brief intervention and referral (SBIRT) for at least some grades in middle and high school has been recommended as an effective prevention and early intervention strategy. In order to examine the efficacy and feasibility of implementing universal screening as part of SBSAS, the following sections of this brief report summarize published guidelines and reviews that address the choice of screening methods used in schools, along with recent research that examines logistical considerations for implementing universal school-based screening (USBS) versus more selective approaches, and the effectiveness of these efforts.

Published guidelines and reviews

Universal screening for adolescent substance use and mental health issues has been advocated in clinical settings. The American Medical Association's (AMA, 1997) Guidelines for Adolescent Preventive Services include recommendations for screening behavioral and emotional conditions, including substance abuse, and specifically recommend that all adolescents should be asked annually about substance use. In its policy statement, "Alcohol Use by Youth and Adolescents: A Pediatric Concern," the American Academy of Pediatrics (AAP, 2010) recommends that clinicians who work with children and adolescents regularly screen for current alcohol use and use brief intervention techniques during office visits. The National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2015) produced in collaboration with AAP a guide for pediatricians that introduces a simple, quick, empirically derived screening and brief intervention tool for identifying youth at risk for alcohol-related problems. The guide reinforces screening for all patients aged 9 to 18 years old. The Substance Abuse and Mental Health Services Administration (SAMHSA)-Health Resources and Services Administration (HRSA) Center for Integrated Solutions (n.d.) says that regular screenings in primary care and other healthcare settings for mental health and substance use disorders should be provided to people of all ages, even the young and the elderly. Mental Health America (MHA, 2018) also supports universal screening for potential mental health problems in the same settings that screening has long been mandated for potential physical health problems, like vision and hearing. MHA believes that early identification of mental health and substance use issues should also occur where and when young people are mostly likely to present concerns, such as in school.

The U.S. Preventive Services Task Force, however, has been less supportive of universal screening practices for adolescents. In 1996, the Task Force concluded there was insufficient evidence to recommend for or against routine screening for drug abuse with standardized questionnaires or biologic assays (U.S. Preventive Services Task Force, 1996), and a more recent

systematic review found that the state of the evidence regarding drug misuse screening in primary care essentially had not changed (Polen et al., 2008). Likewise, in 2002 the Task Force concluded there was insufficient evidence to recommend for or against routine screening of children or adolescents for depression (Pignone et al., 2002), and a subsequent systematic evidence review also did not conclude whether the use of systematic screening in primary care settings improves identification, treatment, and outcomes of depression over standard identification methods (Williams et al., 2009). More recent reviews by the Task Force have concluded that the current evidence is still insufficient to assess the balance of benefits and harms of screening in primary care settings to reduce alcohol misuse in adolescents (Moyer, 2013). The Task Force suggested that primary care providers should consider potential preventable burden (including consequences of adolescent use), costs (including time commitment and potential financial costs for parents and caregivers from lost work hours and travel to and from the provider), potential harms (including anxiety, stigma or labeling, and interference with the clinician-patient relationship), and current practice (including 2003 research showing that most pediatricians and family practice clinicians do not universally or consistently screen for alcohol misuse [Millstein & Marcell, 2003]). Findings from an updated evidence report and systematic review were generally consistent with this recommendation (O'Connor et al., 2018).

Following the lead of the AMA, APA, and other organizations identified above that have endorsed universal screening in clinical settings, some organizations and expert panels have recommended school-based screening for mental health and/or substance use (e.g., Center for School Mental Health, 2018; the President's New Freedom Commission on Mental Health, 2003). School-based screening programs are seen as a way to avoid some of the obstacles and costs encountered in clinical settings as identified above. The distinction between USBS and more selective screening practices in school, however, has not always been recognized in these endorsements. Recommendations that have specifically supported USBS have tended to focus more generally on social, emotional, and behavioral (SEB) issues, along with academic performance, rather than substance use specifically. Even so, it is clear that substance use among adolescents should be considered as a behavioral issue of concern, and one that can impact school performance and healthy adolescent development. For example, universal screening to identify students at risk for school failure or psychological or behavioral problems, including substance use, is increasingly recognized as an important professional practice (National Research Council and Institute of Medicine of the National Academies Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults, 2009). Both the President's Commission on Excellence in Special Education and the No Child Left Behind Act of 2001 (NCLB) have strongly endorsed this approach. In its current 2004 reauthorization, up to 15 percent of the funds available through the Individuals with Disabilities Education Act can be used for early screening, intervention, and prevention to reduce referrals to special education and related services. In a report on minority and gifted students, the National Research Council (2002) recommended that states adopt a universal screening and multitiered intervention strategy in addressing the needs of these school populations, in part to provide services before special education services are needed. Finally, the U.S. Public Health Service (2000) recommended that early indicators of mental health problems be identified in existing education systems and other venues.

A number of research articles have made a case for USBS for both substance use and mental health issues. Schools have been recognized as an ideal setting for detecting social, emotional, and behavioral problems given their widespread access to the majority of youth and their likelihood to follow through with service provision. (Levitt, Saka, Romanelli, & Hoagwood, 2007). The benefits of early identification and intervention have been well-documented (e.g., Cheney et al., 2008), as they were once described as "the most powerful course of action for ameliorating lifelong problems associated with children at risk for emotional and behavioral disorders" (Hester et al., 2004, p.5). Universal school-based screening provides every student equal opportunity to be identified based on risk factors and established markers for mental health and substance use disorders, decreasing the likelihood of missing a student in need of intervention (Lane, Menzies, Oakes, & Kalberg, 2012). Without universal screening, many schools rely on office discipline referrals to determine who is at risk and should receive intervention services, but students may not receive necessary supports until they accumulate a specified number of referrals (Bruhn, Lane, & Hirsch, 2014). Universal screening is designed to identify students with externalizing (e.g., disruption, overt defiance, aggression) and internalizing (e,g., social withdrawal, anxiety, depression) behavioral patterns and is more likely than office discipline referrals to represent students with critical internalizing issues (Walker, Cheney, Stage, & Blum, 2005). Additional research findings regarding USBS implementation issues are provided in the next section of this report.

Data from a systematic review of state-level agencies' web site documents produced between 2012 and 2015 showed that most states include some mention of universal screening, but in nearly half of the states, either this was limited to a brief definition or the information provided focused on academic failure instead of SEB domains (Briesch et al., 2018). Documents that referenced universal screening for SEB risk were found to be largely informational in nature (e.g., describing what universal screening is or how it might be conducted) as opposed to providing specific recommendations or mandates for implementation. Furthermore, documents varied widely with regard to the level of specificity, from briefly mentioning universal screening as an essential component of multi-tiered systems of support to specifically describing how universal screening may be conducted. As of 2015, only one state (New Mexico) provided policy to require universal screening for SEB risk (see https://webnew.ped.state.nm.us/bureaus/safe-healthy-schools/response-to-intervention-rti/). Massachusetts enacted similar legislation in 2016 (see following paragraph). The authors surmise that states have been reticent to mandate universal screening until more evidence regarding its effectiveness becomes available, and procedures to address various logistical concerns and potential negative side effects have been tested. An additional advantage noted for not mandating the specific approach was that it allows school districts the flexibility to customize their procedures to fit the local school context.

In March 2016, Massachusetts passed House Bill 4056, titled "An Act relative to substance use treatment, education, and prevention" (Mass. General Laws chapter 71, section 97, as amended by St. 2016, c. 52, s. 15), which requires each city, town, regional school district, charter school or vocational school in the state to utilize a verbal screening tool for substance use disorders annually at 2 different grade points, beginning in the 2017-2018 school year and as approved by the Department of Public Health (DPH, Bill H.4056, 2016). DPH has deemed SBIRT as the approved screening practice, and the verbal screening tool approved by the Department of Elementary and Secondary Education (DESE) and DPH for district/school use is the CRAFFT-II

Screening Interview. The recommended grade levels are grades 7 and 9. Starting in 2018-2019, the school or district shall notify parents or guardians of the students to be screened, prior to the start of the school year, and a student or the student's parent/guardian may opt out of the screening by written notification at any time prior to or during the screening (Wulfson, 2018). Schools are then required to report aggregate screening data to DPH not later than 90 days after the screenings. DESE is working with DPH to provide information to districts about how to access training, resources, and materials through DPH for use in implementing the screening. Training in the CRAFFT-II Screen is available from DPH to school district staff at no charge, and Massachusetts DPH (2009) has published a screening manual. Districts/schools can access information on the program at SBIRT in Schools. They can also register for a 6-hour *SBIRT in Schools: Introductory Training* at the School Health Institute for Education and Leadership Development site, as well as learn how to register for the optional 3-hour *SBIRT in Schools: Implementation Essentials*. The legislation permits a school district to opt out of the requirement to use a verbal screening tool where the district has implemented an alternative substance use screening policy. DESE will provide a form for school districts to indicate a decision to opt out of the requirement. We have not as yet located any reports describing the implementation of this legislation.

Research on implementation and effects of school-based screening

Numerous research articles have been published over the last 20 years regarding school-based screening for SEB problems, although only a small percentage of these have focused specifically on USBS. The majority of these articles have been published in the past five years, thereby indicating recently increased attention to the potential benefits of USBS and more frequent application of this approach. Most if not all articles reviewed here acknowledge conceptually the rational and potential advantages of USBS, and most of them also reference one or more of the endorsements for USBS from reputable organizations summarized in the preceding section of this report. Four of these articles provide useful, detailed descriptions of USBS applications (i.e., case studies), typically embedded with an SBIRT program. Three articles report findings from surveys of state-level or school personnel regarding SBIRT, including USBS, specifically. The Anderson et al. (2018) article reports the findings of a systematic review of studies that examined the effectiveness of school-based screening for MH issues, and the article by Humphrey and Wigelsworth (2016) provides an insightful overview of both challenges and prospects for more widespread adoption of USBS.

The meaning of the term "universal" varies somewhat across studies. In particular, it has sometimes been applied to settings in which teachers are charged with identifying students through observation or other means who are either experiencing or appear to be at risk for SEB issues. Because any student could potentially be identified through this mechanism, it could be considered a universal approach. A more useful definition is provided by Albers and Kettler (2014): Universal screening is the preventative, systematic, and standardized process of assessing every student for pre-determined criteria (e.g., socio-emotional or behavioral functioning), with the aim of providing early identification and intervention to identified students. We interpret this to mean the use of a standardized and validated screening instrument that can be completed or applied to all students in a school or grade level within a school, and this interpretation has generally been the case for the articles reviewed here.

The conceptual justification for USBS provided in many of the articles reflects points made in the preceding section, most notably:

- The slow uptake of universal screening in health care practice despite recommendations to do so
- The potentially greater reach and efficiencies in conducting universal screening in schools
- Even for substance non-users, substance use screening protocols can be used to provide positive feedback and encouragement regarding non-use
- The opportunity to proactively identify more students who need services as opposed to more selective screening practices or direct referral based on disciplinary incidents
- Potentially greater access to assessment and intervention services, either within the school or through school-community provider partnerships
- The connections between healthy SEB functioning and academic success

Table 1 summarizes the nine published research articles selected for this report. Although many other potentially relevant articles were located, those summarized here were viewed as particularly useful due to their recency and their explicit consideration of universal approaches. Most or all of these articles also touch on logistical challenges and barriers to USBS, and provide examples and/or recommendations for overcoming these obstacles.

Table 1. Summary of recent published research focusing on USBS

Publication	Type of study	Focus[1]	Screening tool(s) used	Findings/Conclusions
Anderson et al., 2018	Lit review on effectiveness and cost-effectiveness of school-based screenings	MH	(Multiple)	Evidence base for drawing conclusions about USBS is still weak. Almost all studies were case studies or quasi-experimental. (Tentative conclusions summarized in text below).
Auerbach et al., 2018	Survey of state-level stakeholders from different states (N=11)	SEB	NA	Although school-based screening for SEB is still uncommon, there is general support from state-level stakeholders. They also perceive that new legislation, initiatives, and partnerships will continue to move the field towards greater levels of acceptance and implementation.
Donohue et al., 2016	Case study	SEB	BASC-2 BESS	Implementation of this universal screening program (used for students in grade levels 3, 6, and 9) has gone well and appears to have positively affected the school district's awareness (by both personnel and parents) of SEB issues and needs of students.
Hamza et al., 2018	Case study	SEB	CRAFFT plus several other MH screens	Reductions in CRAFFT scores were observed following implementation of this universal SBIRT program. The program appears to have been implemented well and the procedures used are described in detail.
Harris et al., 2016	Survey of SBHC program directors and clinicians regarding SBIRT in NY State (N=64)	SA	(Multiple)	Only half of the School Based Health Centers reported doing any screening for substance use and only 22% used a full SBIRT model. Clinicians were especially reluctant to use standardized screeners, with many not seeing it as their role and doubting its usefulness.
Humphrey et al., 2016	Conceptual over-view of issues and prospects	MH	NA	Reviews a number of issues and challenges for USBS, and then provides a vision of what an effective system might look like.
Lunstead et al., 2017	Survey of school MS and HS nurses regarding SBIRT in MA (N=87)	SA	(Multiple)	Although the majority of nurses were supportive of universal screening, none of them reported routine (i.e., universal) screening. Barriers are discussed. (Note: this study was done before the 2016 legislation in MA took effect).
Maslowsky et al., 2017	Case study	SA	CRAFFT	This study provides a description of successful implementation of universal SBIRT in 10 high schools in Wisconsin that do not have in-school health clinics. Outcomes included lower perceived likelihood of using substances after SBIRT.
Torcasso & Hilt, 2017	Case study	SEB	DPS plus clinical interview	Description of a universal multi-stage screening strategy used in one HS in Wisconsin. Outcomes included increased utilization of mental health services and a reduction in suicide ideation and attempts (based on YRBS data). The use of a follow-up clinical interview as part of the screen reduced false positives.

[1]Mental health (MH); Substance abuse (SA); Social, emotional, and behavioral issues including MH and SA (SEB)

As noted in the Anderson et al. (2018) review, the research designs used to study USBS have been weak, and these deficiencies, particularly the absence of randomized controlled studies, is clearly reflected in the studies summarized above. There is also the possibility that only the more successful demonstration projects involving USBS have been submitted and accepted for publication. Keeping these limitations in mind, the outcomes observed in all four case studies reviewed do suggest positive benefits from application of USBS combined with follow-up services as needed. These results are consistent with both speculation and findings from other studies that have shown universal screening to identify greater numbers of students, and sooner, than selective strategies. Even the Anderson et al. review offered the tentative assessment that "some evidence suggests that overall, universal screening may be the most effective method of identification." The authors also point out, however, the typically higher false-positive results produced by this approach, and pointed to a two-stage screening process as one possible variation to help address this issue.

Equally, or perhaps even more importantly, the case studies listed in the table provide useful examples of successful implementation of USBS, and details regarding their implementation acknowledge the challenges encountered and offer strategies and tips based on experience than may help inform application of USBS in other settings. Five main obstacles to USBS implementation were identified in the seminal review on the prevention of mental, emotional, and behavioral disorders by the National Research Council and the Institute of Medicine (2009):

- teachers' concerns that their input will be reduced
- additional work and time involved
- potential stigmatization of identified students
- questions about the validity of discrepant rates of disorders related to gender, race/ethnicity, and economic status
- parental concerns about labeling and consent

Additional barriers the report identified that specifically related to universal screening include cost reimbursement, availability of trained and qualified staff, and the capacity to provide follow-up services to identified students.

Most or all of these barriers were reiterated by the articles reviewed here, and are important issues to keep in mind, and address, in any effort to introduce USBS in school systems. The concern about the potential lack of resources available to serve higher numbers of at-risk students was especially prominent. Other challenges identified in one or more of the articles reviewed here are:

- Lack of understanding and buy-in from teachers, administrators, and parents
- Uncertainty regarding management and use of the data collected
- Unfamiliarity with screening instruments

Suggestions and practices identified in the literature that have been used (or are otherwise expected to be helpful) in addressing the barriers include:

- Educate administrators, teachers, clinical staff, and parents regarding the justification for and benefits of USBS
- Track the outcomes achieved through USBS implementation and use this information to reinforce educational messages and garner support
- Provide training and professional development opportunities to teachers and staff on implementation of USBS
- Develop protocols for USBS in collaboration with community partners, including coalitions, providers, and parents
- Use non-school affiliated personnel to implement the screening programs to help ensure confidentiality
- Consider the use of electronic screeners to reduce demands on staff time and increase objectivity

The appropriateness of suggestions like these, and others, will certainly depend on the specific context of where they might be applied. The final section of this report provides recommendations for USBS that would seem especially promising and useful for Vermont's SBSAS program.

Summary and Recommendations

Although rigorous research evidence is still lacking regarding the benefits of USBS, there is compelling conceptual justification for why the approach could effectively be used to identify more at-risk students, and do so earlier, than selective screening practices. Additionally, a number of case studies provide useful examples of how USBS can be successfully implemented. Reservations regarding USBS have focused primarily on challenges regarding implementation, costs, lack of understanding and support, potential for stigmatization, and concerns about capacity to meet the service needs of all those students identified as needing services.

Those reservations are understandable and they likely have contributed to reluctance by state education agencies and state legislatures to mandate or even strongly recommend USBS at this time. Rather, the decision to implement USBS in most states is left to individual districts based on their own unique circumstances. For districts that believe they can adequately address the challenges faced in effectively implementing USBS, doing so would appear to be a reasonable course of action with the potential for improving student SEB health and related outcomes.

No SBSAS-funded SUs in Vermont currently employ USBS in their screening and referral protocols. While there are valid reasons for why it may be difficult or even counter-productive for many grantees to abruptly adopt USBS, there may be some grantees that are capable of taking on this challenge successfully. One recommendation for ADAP, therefore, is to identify a small subset of grantees that are interested in participating in a pilot study to implement USBS as a component of their SBSAS grant. Extra funds could be provided as an incentive for participating and used to offset some of the higher costs and time commitment that would likely be needed. The main purpose of this pilot would be to help facilitate the implementation of

USBS in selected SUs and assess its implementation, including costs, challenges encountered, and how the challenges were addressed. Screening and referral data collected from the grantees could also be examined for direct evidence of more students being screened and other anticipated outcomes such as higher numbers of students identified as needing services and being referred to services, both pre- and post-pilot and compared to other SUs.

In light of the broad variability in the percent of students who are screened across Vermont's SBSAS grantees, we also suggest conducting interviews or focus groups (or including additional questions in the biannual reporting tool) to learn more about:

- The specific approaches and criteria used in schools to identify students for screening with the screener tools
- Perceived barriers and potential advantages of doing universal screening
- The other ways that students are determined to have "screened positive" (other than through the CRAFFT or GAIN-SS)

Additional suggestions for enhancing and assessing the impacts of SBSAS screening protocols include:

- Add items in the Survey Gizmo tool to track how many students are identified as positive screens through the CRAFFT or GAIN versus other means
- In light of what is learned from the qualitative research suggested above, and in order to facilitate more consistent screening practices across SUs, develop guidelines and specific criteria regarding how students should be selected for screening in SUs where USBS is not implemented
- Based on findings from the USBS pilot suggested above along with this report and other resources, prepare guidance for grantees regarding the potential benefits of USBS and strategies for overcoming barriers to implementing this approach

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Attachment A. SBSAS Screenings 2017-18 School Year

SU	Screener used	Grades 6-12 enrollment	Total number screened with CRAFFT or GAIN	Percent of students screened with CRAFFT or GAIN - grades 6-12	Number who screened positive for possible SA[1]	Percent who screened positive for possible SA	Number referred for SA assessment[2]	Percent of positive screens referred for SA assessment	Number that were referred for SA assessment and received services[2]	Percent referred for SA assessment that received services	Number who screened positive for possible MH disorders[1]	Percent who screened positive for possible MH disorders	Number referred for MH assessment[2]	Percent of positive screens referred for MH assessment	Number that were referred and received MH services[2]	Percent referred that received MH services
Addison Northwest	CRAFFT	517	8	2%	2	25%	1	50%	1	100%	0	0%	0		0	
Barre	CRAFFT	1119	73	7%	26	36%	19	73%	13	68%	37	51%	21	57%	11	52%
Burlington	CRAFFT	1786	47	3%	27	57%	21	78%	13	62%	56	119%	52	93%	37	71%
Essex Caledonia	CRAFFT	129	7	5%	4	57%	4	100%	3	75%	6	86%	4	67%	4	100%
Lamoille South	CRAFFT	878	101	12%	39	39%	39	100%	27	69%	6	6%	6	100%	6	100%
Springfield	CRAFFT	657	86	13%	5	6%	4	80%	3	75%	29	34%	18	62%	14	78%
Washington South	CRAFFT	294	26	9%	1	4%	1	100%	0	0%	8	31%	8	100%	6	75%
White River Valley	CRAFFT	520	48	9%	16	33%	13	81%	7	54%	2	4%	2	100%	1	50%
Windham Northeast	CRAFFT	558	19	3%	6	32%	5	83%	5	100%	56	295%	53	95%	42	79%
Windham Southwest	CRAFFT	228	60	26%	21	35%	20	95%	2	10%	29	48%	29	100%	11	38%
Totals for CRAFFT group		6686	475	7%	147	31%	127	86%	74	58%	229	48%	193	84%	132	68%
Addison Rutland	GAIN-SS	687	15	2%	8	53%	8	100%	0	0%	13	87%	13	100%	2	15%
Franklin West	GAIN-SS	705	9	1%	7	78%	7	100%	6	86%	3	33%	3	100%	3	100%
Southwest VT	GAIN-SS	1503	31	2%	6	19%	5	83%	5	100%	36	116%	31	86%	29	94%
Two Rivers	GAIN-SS	528	50	9%	16	32%	15	94%	10	67%	29	58%	23	79%	16	70%
Champlain Valley	mix	2177	167	8%	81	49%	73	90%	36	49%	86	51%	85	99%	45	53%
Chittenden East	mix	1334	48	4%	23	48%	19	83%	18	95%	38	79%	24	63%	22	92%
Franklin Northeast	mix	822	176	21%	35	20%	35	100%	23	66%	74	42%	74	100%	58	78%
Maple Run Unified	mix	1344	48	4%	6	13%	6	100%	2	33%	26	54%	26	100%	17	65%
North Country	mix	1227	58	5%	12	21%	9	75%	2	22%	10	17%	8	80%	2	25%
Windham Southeast	mix	1296	93	7%	68	73%	66	97%	39	59%	81	87%	79	98%	48	61%
Totals for GAIN/mix group		11623	695	6%	262	38%	243	93%	141	58%	396	57%	366	92%	242	66%
Total for all		18309	1170	6%	409	35%	370	90%	215	58%	625	53%	559	89%	374	67%

[1]Includes students who screened positive based on the screening tools or through other procedures.

[2]If the number referred or received services for either SA or MH assessment was greater than the number screened positive, the number referred was adjusted to equal the number who screened positive.