



School-Based Outpatient Treatment For Adolescent Substance Abuse

A Review of Program Models in Washington State

Prepared for

Office of Superintendent of Public Instruction

Old Capitol Building
PO Box 47200
Olympia, WA 98504-7200

Prepared by

RMC Research Corporation

522 SW Fifth Avenue, Suite 1407
Portland, OR 97204

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This report was prepared by Katherine Carlson. Dennis Deck and Karla Wadeson provided editorial assistance. John Hughes, Office of Superintendent of Public Instruction, provided the overall direction for this project.

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The Prevention and Intervention Services Program's Link to Academic Improvement

Dr. Terry Bergeson
State Superintendent of Public Instruction

Thomas J. Kelly
Associate Superintendent
Operations and Support

Marcia L. Riggers
Coordinating Director
Learning and Teaching Support

John Hughes
Program Supervisor
Prevention and Intervention Services

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Introduction

The dominant model for providing early intervention services in school settings to adolescents with substance abuse and related problems is the student assistance program (Carlson, 1994; Klitzner, Fisher, Stewart, and Gilbert, 1992; Moore and Forster, 1993). In Washington State, more than two-thirds of the middle and high schools participate in the state's student assistance services initiative, the Prevention and Intervention Services Program, which served over 20,000 students during the 1999–2000 school year (Deck and D'Ambrosio, 2000). Here, as elsewhere, student assistance programs provide a range of services, beginning with primary prevention and extending through early intervention in substance abuse to referrals to more intensive treatment resources and recovery support groups.

The review of early intervention and student assistance programs conducted by Klitzner found that adolescent substance abuse treatment was “the ‘weak link’ in the adolescent continuum of care posited by student assistance programs (Klitzner et al, 1992, p. 22).” This characterization is based on their finding that adolescent treatment was often unavailable or ineffective, thus calling into question the capacity of student assistance programs to satisfactorily assist students needing treatment. Klitzner maintained that “the ultimate effectiveness” of early intervention programs rests on resolution of these concerns (Klitzner et al, 1992, p. 21). Some Washington's schools are addressing these issues of treatment availability and effectiveness through by arranging for the delivery of treatment in certified outpatient programs in a school setting. This treatment innovation responds to the identified need for the development of school programs that offer more comprehensive services for youth and their families (Bukstein, 1994; Jenson, Howard, and Yaller, 1995) and fosters the type of integrated approach for the healthy social and emotional development of students that has been called for by advocates of improving school-based supportive services (Adelman and Taylor, 2000)

This discussion paper reviews the rationale behind and the issues associated with such school-based substance abuse treatment. The paper begins with a brief review of the literature on adolescent treatment and consideration of this literature in terms of its relevance to the delivery of treatment services at schools. The paper concludes with an analysis of the current status of school-based treatment in Washington and its advantages, challenges, and requirements for implementation and operation.

Adolescent Substance Abuse Treatment and Schools

The research literature on adolescent substance abuse consistently identifies prevention and early intervention as the most appropriate strategies for responding to the risks of juvenile problem behaviors (Steinberg, 1991; Werner, 1991). This finding supports the current emphasis on student assistance programs. Not all adolescents, however, benefit from or respond satisfactorily to prevention or early intervention efforts; some need more intensive intervention. The majority of adolescents who meet the criteria for substance abuse or dependence are referred to outpatient treatment (Dusenbury, Khuri, and Millman, 1992).

The research literature says almost nothing about school-based treatment. The only type of program described involves full-time attendance at some form of a combined treatment/school facility that separates the students in treatment from regular students. Patients in these programs return home at night and on weekends. Such an approach is more controlling and intrusive than regular outpatient treatment, and thus relies somewhat less on patient motivation for attendance and participation. An evaluation study of one full-time program of this type found that the program strengthened the students' commitment to education and promoted good school habits. Although substance use during the school day was generally eliminated, self-reports from the students indicated that the program had little effect on their use when they left school or completed the program (Beschner, 1985).

Despite the absence of references to school-based substance abuse treatment programs such as those operating in Washington State, there is substantial indication in the research on adolescent substance abuse and community-based treatment to support their further consideration. Not least of these indicators is the fact that schools are among the most important social institutions for adolescents, second only to families in significance. Schools give the most efficient access to the adolescent population, are justifiably concerned with health-compromising behaviors because of their relationships to other problem behaviors, and are in a unique position to change children's interactions and behaviors and to model community standards (Freidman and Beschner, 1985; Perry, 1986). The public school is the best place to identify and reach most youth, including the majority of those adolescents who abuse or are dependent on alcohol or other drugs. Although substance abuse is a factor in school dropouts and some adolescents needing treatment are not attending school, the adolescents who enter treatment in Washington are typically enrolled in school (Andris, Kamara, Loudon, and Mumwaw, 1992).

Referral

The school's role begins with the referral for treatment services. This finding is particularly evident in Washington State, where school-based substance abuse services have contributed to a dominance of school referrals for treatment that is not typical elsewhere. The literature confirms that adolescents seldom enter treatment for substance abuse without some coercion (Catalano, Hawkins, Wells, Miller, and Brewer, 1991). Most are brought into treatment by parents or school officials or through the criminal justice system (Brown, 1989; Cook and Petersen, 1985; Dusenbury et al., 1992). Beschner (1985) provided a ranked listing of problems identified by adolescents as reasons for entering substance abuse treatment. These included family-related problems (identified by 49 percent of the participating adolescents); school-related problems (40 percent); legal problems (35 percent); and emotional or psychiatric problems (28 percent). Andris et al. (1992) found that among the adolescent substance abuse treatment clients of Washington State's Division of Alcohol and Substance Abuse (DASA), 30 percent had been referred by schools, 23 percent had been referred by juvenile authorities, and 20 percent had been referred by families. This finding shows that in Washington schools are an important avenue leading to adolescent treatment entry, serving both as a common source of problems contributing to the need for treatment and as the source of many treatment referrals.

Treatment Retention and Completion

Adolescents are like their adult counterparts in having poor rates of treatment retention, often leaving or discontinuing treatment programs prior to the completion of services (Titus and Godley, 1999). Several factors contribute to better treatment outcomes. The evidence indicates that successful treatment is associated with involvement in school; for example, Dusenbury et al. (1992) found that those adolescents with the best treatment prognoses tended to be enrolled in school or another educational program, and Arella (1993) found that positive outcomes were associated with participation in vocational training programs. Educational involvement has also been identified as a factor that correlates with reduced difficulties before treatment, lower rates of in-treatment relapses, and more likely posttreatment success (Catalano et al., 1991). A Washington State study (Andris et al., 1992) found that the treatment completers were more likely to have been referred to treatment by schools or juvenile authorities than other sources.

Recovery and Aftercare

The prognosis for most adolescents—even those who complete treatment—is often poor. Klitzner et al. (1992) cited relapse rates ranging from 35 percent to 85 percent. Dusenbury et al. (1992) reported that one-third of the youth who relapse after treatment do so in the first month after completion, whereas Brown, Mott, and Meyers (1990) noted relapse rates of 64 percent within the first three months after treatment and another 7 percent four to six months after treatment. A more recent 18-month follow-up study of adolescents completing treatment in Washington State identified better outcomes, finding that a majority of both inpatient and outpatient study participants had been recently abstinent (New Standards, 1997). More than two-thirds of the study participants had at least one six-month posttreatment period of abstinence. This study also concluded that treatment completion did have measurable benefits. Significant evidence of improved school performance and reduced school disciplinary problems and formal legal involvement supported this finding.

In the New Standards (1997) study, involvement in continued care after treatment was the most important predictor of positive outcomes for adolescents over time. Aftercare (also known as *continuing care* or *extended care*) is widely considered to be essential to maintaining treatment improvements among the adolescent population (Dusenbury et al., 1992; Hawkins, Lishner, Jenson, and Catalano, 1987). Shiltz (1993) found that the more aftercare meetings adolescents attended, the less frequently they used drugs. Like the treatment itself, the aftercare should be specific to adolescents and their needs (Winters, 1999). Effective aftercare services may be located in the community or the school, or both.

The school environment is also important to the process of recovering from substance abuse because the school's prominence as a primary location for peer relations. Adolescents appear to relapse most often as a result of peer pressure, in contrast to adults whose relapse is more tied to negative affect or personal distress (Dusenbury et al., 1992). Studies of adolescents who have completed inpatient treatment (Brown, 1993; Brown et al., 1990) have revealed that the most important precursors for relapse are the social and environmental contexts. The presence of social support for abstinence is strongly correlated with posttreatment success. Catalano et al. (1991) referred to study results suggesting that involvement with prosocial peers and participation in prosocial activities are likely aspects of successful outcomes. Brown et al. noted that perceptions of social network support are related to posttreatment abstinence, and abstainers have reported receiving more support from new friends made since treatment completion.

School-based recovery support following treatment completion or aftercare services can help abstaining adolescents by providing them with access to a social network of others who do not use alcohol or other drugs and by connecting them with a supportive adult (Brown et al., 1990; Catalano et al., 1991). The delivery of substance abuse services at a school site contributes to engaging high-risk parents; their involvement is facilitated by the close connection of the program to the already familiar school setting (Dishion and McMahon, 1998). In situations that involve parents who cannot or should not be engaged in the treatment of their child, Catalano et al. (1991) recommended the participation of another responsible adult in the parental support role. Teachers or other adults at school—such as prevention and intervention specialists—may be good candidates for this role because adolescent attachment to either or both parents and teachers is related to positive self-concept and academic motivation. School-based intervention programs that enhance adolescent relationships with adults can also counter the significance of peers for high school-aged youth (Learner and Kruger, 1997).

Rationale for School-Based Treatment Services

The research literature on treatment for adolescent substance abuse reveals that schools are a significant factor in this intervention. School authorities are often responsible for referring youth to services and youth who remain associated with schools tend to do better at all phases of the treatment process. Offering outpatient treatment inside the school rather than in the community builds on this existing connection. School-based treatment is congruent with the characteristics of adolescents seeking substance abuse treatment in Washington State, where some 80 percent of the adolescents in substance abuse treatment are students (Andris et al., 1992). This approach takes advantage of the effectiveness of the state's current, extensive use of school-based referral sources and follow-up offerings provided through its Prevention and Intervention Services Program.

School-based delivery of adolescent substance abuse treatment also promises to resolve some of the major concerns associated with community-based treatment. Klitzner et al. (1992) identified these concerns in three categories: availability, quality, and effectiveness. Attention to the resolution of these problems should also strengthen core student assistance services.

Availability

The concern about the availability of substance abuse treatment for adolescents has several dimensions. The first of these dimensions is the most obvious—the availability of adequate services to meet the demand. Furthermore, these treatment services must be designed for youth because adult-oriented substance abuse treatment is not appropriate for adolescents. Specialized adolescent programs are not available in many communities. Where such programs do exist, adolescent treatment services frequently have waiting lists, a situation especially likely for inpatient programs. Although inpatient services are part of the continuum of care, public schools are not generally in a position to deliver inpatient treatment, and the issues related specifically to adolescent inpatient treatment are not the focus of this paper.

Community-based outpatient treatment programs that serve adolescents are most likely to be concentrated in urban or populous suburban communities. Rural areas and smaller communities are much less likely to offer specialized adolescent treatment. Thus the location of outpatient treatment resources may present transportation problems for adolescents. Parents may be available to provide transportation to treatment services due to

work or other demands or due to a lack of support for their child's treatment involvement. Younger teens do not have driver's licenses, and older teens may not have vehicles or their driver's licenses may be suspended due to use-related infractions. Public transportation, which is unavailable in many rural and suburban areas, can be very time consuming. Treatment access problems can pose very real barriers even for highly motivated youth. For adolescents with less motivation, these difficulties accessing services further reduce the likelihood of successful treatment follow-through.

School-based treatment can most readily resolve access issues when treatment is offered during the regular school day, thus piggybacking on existing means of transportation. School bus service may be a significant part of this approach to services. One school-based treatment program in Washington formerly operated in a skills center and was able to take advantage of the regular bus transportation offered to students from district schools served by the center.

The intervention specialists who serve Washington students through the Prevention and Intervention Services Program have indicated that access issues also contribute to service decisions. In communities where treatment is unavailable or access problems render treatment clearly unfeasible, youth may be less likely to be referred for treatment services. The implication is that the need for treatment may not be well reflected by the state's Prevention and Intervention Services Program statistics. Indeed, the statistics for the 1999–2000 school year show that more youth were referred for an assessment of need than were referred for services, and more yet were identified as abusing or dependent on alcohol or other drugs and thus as potential treatment candidates but were not referred for assessment. Intervention specialists in rural communities have noted transportation as a barrier to formal assessments conducted by referral to a community-based treatment provider. Adelman and Taylor (2000) have maintained that offering health-related services at schools facilitates access, especially for underserved and difficult-to-reach populations. Several of the sites for school-based outpatient programs in Washington are in communities that previously had no adolescent treatment services.

Adolescents who have dropped out of school or who have been expelled from school are not necessarily denied access to school-based treatment programs. Nonattending youth are served by after-school programs located at alternative schools; youth who are sentenced to at least 30 days in detention are served by another program operating as part of the detention center's school (the treatment services are delivered at a community school at another site). For such youth, participation in treatment at a school site or as part of a

school program may contribute to a reconnection with education and lead to re-enrollment in school or involvement in a GED program.

Quality

Adolescent problem behaviors, and particularly adolescent substance abuse, generally occur as a complex set of issues involving many behaviors. The optimal model for health-related services to adolescents is that of a system of care in which there is a coordinated response to multiple concerns and service needs. In its community-based form, adolescent treatment represents a break in such an ideal service continuum, separating the adolescent from the school-based student assistant program and other school services and requiring him or her to go elsewhere for treatment services. Keeping treatment services on-site eliminates this physical and systems break. With school-based treatment, the steps that are required between treatment referral and treatment entry simply involve completing the appropriate paperwork; thus follow-through should improve.

When the intervention specialist and the treatment provider are the same individual, even the service delivery is seamless. The presence of the intervention specialist, either as the treatment provider or as part of the treatment system, facilitates the resolution of problems and aids the placement of adolescents into alternative treatment settings if necessary, including inpatient programs. Other school personnel need to know about an adolescent's progress during treatment and immediately thereafter. For example, if a school administrator's actions precipitate treatment entry, the student's continued school enrollment may be contingent on the student's satisfactory progress in treatment. When school administrators, counselors, teachers, and other school staff are physically and operationally separate from the treatment setting, they are less likely to be available to offer assistance and support, encouragement, or consequences for noncompliance.

Schools often have preexisting relationships with parents that can facilitate family involvement in the treatment process. Schools are settings without the stigma associated with community-based substance abuse services, and parents are likely to already be comfortable with the setting and its associations. Adelman and Taylor (2000) observed that families who use school-based centers are also likely to become involved in other school activities and initiatives, thereby improving community links with the school and contributing to improved outcomes for collaborative efforts.

Schools may also have established relationships with other community service agencies that can contribute to the coordination of services on the campus. For youth involved with the court system, school attendance is a standard requirement of probation, and probation officers are in frequent contact with schools to monitor these students' attendance and to respond to any violations or disciplinary issues. School or educational service district (ESD) personnel are responsible for ensuring that academic work continues for youth in detention, and detention services thus also have a ready connection to schools. In many communities, this collaboration between schools and the juvenile justice system takes the form of joint participation on task forces or committees charged with monitoring youth with problem behaviors. Mental health service providers may also be involved in service partnerships with schools, both for referrals and for the delivery of school-based programs. One current school-based treatment program in Washington serves students with dual substance abuse and mental health disorders; a mental health counselor cofacilitates the services with a chemical dependency counselor from a nonprofit treatment agency.

Effectiveness

Improvements in both the availability and quality of services are directly linked to the potential for improved treatment outcomes and effectiveness. School-based treatment puts administrators, teachers, and other staff in a better position to monitor treatment participation and improve retention. The latter is particularly important for schools using adherence to the recommendations of the intervention specialist as a condition or alternative to disciplinary sanction. Retention in treatment can also be enhanced if participation in treatment is incorporated into the regular school schedule. Attendance at treatment sessions becomes linked with school attendance, a connection that should enhance participation among youth who do not have high rates of truancy. For students with attendance problems and students at risk of failing to meet graduation requirements due to insufficient academic credits, outpatient treatment may be delivered as a class, complete with the prospect of earning credits for attendance and completion. Both programs that operate during the school day and programs that operate after school use this approach. Credits are an incentive to attend and complete treatment.

One of the most important advantages of school-based substance abuse treatment is improved participation in recovery support groups after treatment completion. Participation in posttreatment services is closely tied to better outcomes. Recovery services offered in schools can link youth with supportive adults and nonusing peers in an important setting

for peer contacts. Recovery services offered in the community have all the disadvantages and difficulties of community-based treatment, plus likely additional problems associated with a reduced intensity of service. In the same way that school-based treatment eases the transition to engaging in treatment services and maintaining participation, school-based treatment facilitates access to follow-up services. These posttreatment services may be delivered by the same staff person who provided treatment services and may involve connections to other school personnel and administrators, who serve as additional sources of support and sanctions for participation.

Models of School-Based Treatment in Washington

Three models for school-based substance abuse treatment are in place in Washington State. The first, Model I, is the approach presently used in treatment programs operated through two ESDs. Model I utilizes an educational entity—an ESD or potentially a local school district—to deliver both prevention and intervention services and treatment services. ESD 113 and ESD 114 are certified treatment agencies, and both also provide Prevention and Intervention Services Program services to schools in their regions. The second approach, Model II, utilizes private treatment agencies to provide these services. In one eastern Washington county where this approach is used the ESD contracts with a private provider for prevention and intervention services. A school district in the ESD 114 region also uses the Model II approach; in this case the ESD contracts with a private treatment provider to provide early intervention services at a particular school, and the county contracts with that provider to also deliver substance abuse treatment at that school. The third approach, Model III, utilizes ESD or school district staff to provide prevention and intervention services and utilizes a private, certified substance abuse treatment agency to provide school-based treatment services. This pattern characterizes one Puget Sound School District. Each model has some logistical and bureaucratic advantages and disadvantages, and each model appears to be linked to local conditions or practices. Table 1 summarizes these three models and their principal characteristics.

**Table 1
Comparison of School Based Treatment Models**

Treatment Model	Prevention and Intervention Program Services	Outpatient Substance Abuse Treatment Services	Potential for Integration With School Services	State Certification
Model I	ESD/School district	ESD/School district	High	Certification required
Model II	Private provider	Private provider	Moderate	Certification in place
Model III	ESD/district	Private provider	Low	Certification in place

Model I has the highest potential for integration with other school services because an educational agency delivers both the prevention and intervention services and the treatment services. Model II has moderate potential for service integration; this potential is dependent upon the specific personnel involved and their relationships. That is, where good collaboration occurs, integration may well be very complete. Model III has the weakest potential for attaining good integration with other school services—including the

services of student assistance programs—due to the use of different providers for the two types of services and the probability that different staff will deliver these services. Again, however, this arrangement may nonetheless be satisfactory, depending upon the specific personnel involved and the nature of their relationships.

The principal advantage of Models II and III is associated with the requirement of state certification as a treatment agency. ESDs or school districts desiring to implement these models of service delivery must complete and fulfill the certification application and review process. Although the process is not insurmountable or particularly onerous in itself, it does involve paperwork, the satisfaction of certain requirements, and the establishment of a formal relationship with the state's Division of Alcohol and Substance Abuse. Established treatment providers in the community already have this certification. Washington recently relaxed the requirements for a certified agency to be able to offer its services off site—in schools, for example—and as of 2001 licensed treatment agencies do not need separate certification for their staff to provide services elsewhere.

The initiation of the ESD-delivered approach (Model I) was primarily in response to a general lack of private providers in the service area and concerns about the quality of the providers that were available. Under this model the same staff may or may not provide both prevention and intervention services and treatment services, but ESD or district personnel fill both types of staff positions. The use of a private provider to deliver treatment services, as in Model II, is a natural choice when prevention and intervention services are delivered under contract with a treatment agency. As in the case of Model I, staff may or may not have combined functions, but both positions are filled by a private service provider. Finally, opting for Model III and bringing private providers into the school solely to deliver outpatient treatment services may be an efficient strategy when suitable providers are available in the area, regardless of the staffing plan for prevention and intervention services.

Considerations

Prevention and intervention services administrators in school districts and ESDs are pondering the development and implementation of school-based treatment for the very reasons identified by Klitzner et al. (1992) nearly ten years ago: availability, quality, and effectiveness. Improved access to needed treatment services is by far the most important impetus for the implementation of a school-based substance abuse treatment program. Community-based outpatient substance abuse treatment services for adolescents are often overextended and the services that do exist in rural and suburban areas are effectively inaccessible to large segments of the population due to barriers posed by geographic and transportation issues. The cost of community-based services can also be a barrier.

Fewer concerns about the quality of community-based treatment services are likely to be a factor than in the past, but not all of the concerns have been resolved. Treatment content may still be structured for adults and be ill suited or inappropriate for adolescents and their needs. Of greater concern is the fact that community treatment agencies that serve adolescents tend to come and go, reflecting an unstable funding environment. Such agencies also tend to have high rates of staff turnover, often a consequence of low salaries and difficult working conditions. Also, although all treatment staff must meet state standards for certification, there are no requirements that the qualifications include experience working with youth or with schools.

The ideal for school-based services would resolve the most significant of these access and quality concerns by placing treatment in school buildings under the more direct control and oversight of district or ESD staff. The principal advantage and appeal of school-based treatment is at least partially this capacity for an educational entity to exercise some authority over a greater scope of substance abuse services. Whatever the service delivery model, the school system will inevitably have a more significant role in school-based treatment than community-based treatment. This role permits a larger say in the selection of staff, more attention to program content, and increased supervision of operations. In theory, this input should in turn lead to improvements in effectiveness and outcomes.

The translation of these theoretical advantages into successful practice entails more than a simple decision to deliver substance abuse treatment services in schools. The experience of those who have already initiated school-based treatment is that a range of factors must be

addressed before proceeding and that these factors require further attention in the course of delivering services.

School Commitment

Despite the seeming advantages of implementing school-based substance abuse treatment services, the idea may encounter considerable resistance. Treatment delivery represents a considerable expansion of substance abuse services, and some school board members and administrators do not yet fully accept the legitimacy of such interventions on campus. Adding treatment to the present prevention and intervention services may be perceived as inappropriate and in conflict with the school's role. School staff may also prefer to keep away from students who have been identified as having substance abuse problems and expelled; these staff may believe that permitting such students to return to school for the purpose of treatment is unacceptable. Current preoccupations with state testing and academic outcomes contribute to this resistance to school-based substance abuse treatment.

Commitment from school administrators is also required to ensure satisfactory conditions for service delivery. Space is likely to be a significant factor in decisions about when and where to offer substance abuse treatment services. The initial ESD 114 program at a skills center shifted to an alternative school when the classroom space used by the treatment program was needed for the regular skills center students. Class schedules can also interfere with treatment delivery. Because alternative schools have already accepted the need for different modes of delivery and routinely employ innovative approaches for their students, treatment services often fit more easily within the alternative school structure. Skills centers similarly offer a different delivery system, and thus can potentially be more readily adapted to house a treatment program. The skills center program at ESD 114 was disrupted when the participating districts implemented alternate-day, block scheduling for skills center students. Doing so addressed the students' transportation and learning needs, but was incompatible with the treatment program's schedule. "Schools are not going to adjust to treatment," warned a veteran of this experience, "treatment will have to adjust to schools." In most current programs treatment generally occurs after school rather than during the school day due to a shortage of dedicated space for what may be only a few hours or days a week. Such programs are not optimal, but are possible in most schools.

Selection of a Service Delivery Model

Deciding to deliver school-based substance abuse treatment requires the choosing of a model for this delivery. Currently, a few of the Prevention and Intervention Services Program projects operate by contracting with private, community-based treatment providers. The most efficient and immediately obvious choice for these projects would be to extend these contractual relationships to include school-based treatment. Doing so necessitates that the treatment agency be interested in delivering its services in what is sure to be a less controllable and in some ways foreign environment. Community-based agencies may be more protective of treatment services than of prevention and intervention services and may be unwilling to cede some portion of their autonomy to schools. Staffing may be another problem. Working in a school requires some different skills than are necessary in an agency, and experienced treatment personnel may not necessarily have these skills or the desire to acquire them.

The majority of the program's projects, however, are staffed through their school district or the ESD, and for these projects the choice of a school-based treatment delivery model entails making several perhaps difficult decisions. Opting to contract with a private provider for treatment services circumvents the need to obtain state certification, but continues the separation of prevention and intervention services from treatment services. Integrated staffing appears to have advantages, and these advantages seem to be greatest when the same individual fills both roles. This arrangement favors a treatment program administered by the ESD or school district. Offering treatment requires more than certification, however, and finding staff with the desired qualifications to fill both the prevention and intervention and treatment roles can present a challenge. Current prevention and intervention staff may not welcome an expansion of their jobs into treatment delivery, particularly if such a change is not accompanied by an increase in staffing or a reduced caseload to compensate for the expanded duties.

Making contractual arrangements with a private treatment provider also presumes that an acceptable treatment agency is available to offer services on campus. In rural areas this scenario is unlikely. Even in urban areas treatment providers that serve adolescents may already be operating at their staff capacity. Staff at community-based treatment agencies are also unlikely to have experience with school settings and the expectations and requirements of school administrators and teachers. If an available community treatment agency with a suitable staff is available, contracting with that agency to deliver school-based substance abuse treatment services potentially allows for nearly immediate program

implementation—assuming the requisite commitments. Contracting with community treatment agencies to provide these services also quells any claims of school competition with private treatment providers.

For the school itself to become the substance abuse treatment service provider, whether by way of the district or through the ESD, is an extension of common practice. The situation is not dissimilar to schools administering the Prevention and Intervention Services Program rather than contracting out this function. Also, schools currently have contractual relationships for needed student services with various community-based providers. Where more than one such service provider exists, these arrangements may be in response to a request for proposals, based on prior relationships, or based on some particular selection criteria. Nonetheless, the implementation of school-based substance abuse treatment may threaten the survival of some community-based treatment agencies or programs. In some locations, delivering outpatient treatment on campus has apparently contributed to the closure of community-based treatment agencies due to the consequent loss of clients and funding.

County Commitment

Funding support for school-based substance abuse treatment may come from a combination of sources, with the most significant of these sources brokered through the substance abuse coordinator in the host county. State funds for outpatient treatment for adolescents are distributed through county coordinators, and school-based programs need to be able to access these funds to pay for treatment services for clients without other sources of support. Although some youth may have private insurance coverage, existing school-based treatment providers rely heavily on their ability to access Title XIX (Medicaid) and state treatment dollars to pay for services. Other funds, such as funds for youth involved in the juvenile justice system, may also be significant for program operations.

Securing commitment from the county is dependent upon several factors, not the least of which are the existing services and previous practice. County coordinators, like school administrators, may be reluctant to support an expansion into the treatment of substance abuse at schools. Relationships with community-based treatment providers may play a role in this reluctance.

Service Issues

Some of the issues associated with school-based substance abuse treatment services do not apply to community-based treatment services. School services cannot deny access due to inability to pay, a position that underscores the necessity of having access to county funding. Despite this fact, the initial operations of a school-based treatment program may be difficult to sustain. School-based services in one Washington county were discontinued when too many participants neither qualified for county support nor had their own funding. The former director of this program believes that this difficulty was a start-up issue that would have been resolved with more experience and a fully operating program, but this example underscores some of the problems new school-based treatment programs might encounter. School-based treatment is, at best, likely to be a break-even service.

The delivery of treatment services in a group settings requires some minimum number of students. Too few students render the model for delivery inefficient and perhaps ineffective. This problem cannot be remedied by forming a group from students of different ages because the span of developmental difference that separates middle school and high school students is too great. To ensure the effectiveness of the treatment services, the time dedicated to providing the services at each school site must be sufficient. Treatment services cannot effect optimal outcomes if staff spend only a few hours a week on campus.

ESD 113 has found that it can provide substance abuse treatment services even in small schools, but sometimes students must wait until others are identified to form a treatment group. This finding suggests advantages for sites with the greatest number of potential treatment candidates, and thus perhaps accounts for the concentration of school-based treatment in alternative schools. Alternative schools and other more flexible educational settings such as community or continuation schools are also more likely to accept students whose presence on the regular campus is unwanted or forbidden. After-school programs at regular schools can also be fairly nonrestrictive and may accept participants who may be suspended or expelled or who have dropped out.

When both prevention and intervention services and substance abuse treatment services are delivered at the same site, program administrators and staff need to ensure a balance between these services. Both types of services will likely make more demands for staff time than can be accommodated. This demand can be managed easily if the programs have separate staffing, but such separation may also contribute to poor program integration. The evidence suggests that independent prevention and intervention personnel do not

necessarily refer students to available school-based treatment services. Veteran Prevention and Intervention Services Program staff have established referral relationships with community-based treatment providers; without a concerted effort to create new relationships, the mere presence of treatment personnel on campus is not enough to interrupt these patterns.

The state requirements for the confidentiality and security of records should already be part of a school's student assistance program. For the most part, the provision of school-based substance abuse treatment services does not increase these demands. Staff not accustomed to working in the relatively open and sometimes chaotic environment of a school may experience some difficulties meeting these mandates, at least until they have learned to work effectively in the school setting. Treatment services are accompanied by an additional set of paperwork requirements that are both different and more extensive than those used associated with the provision of prevention and intervention services. Treatment staff accustomed to providing services in a community setting will be familiar with these requirements while prevention and intervention services staff who also provide treatment services are likely to find the paperwork associated with the provision of treatment services to be burdensome.

Conclusions

The administrators and supervisors of Washington’s Prevention Intervention Services Program have expressed considerable interest in implementing school-based substance abuse treatment services. The promising accounts of such efforts in ESD 114 and ESD 113 and the more localized experiences of schools in Yakima and Federal Way have stimulated this interest. The appeal of formally considering and developing these services is further fueled by persistent difficulties finding satisfactory treatment placements for needy students. The specialized needs of adolescents are more pronounced in some regions but are generally present in all geographic and demographic areas across Washington.

Several critical elements must be addressed to ensure the effective delivery of school-based treatment services:

- **Certification**—The treatment provider must be approved by the state. If the district or ESD is to assume this role, it must be prepared to assume responsibility for completing the state’s requirements and adhering to all state and federal requirements. These requirements will demand some initial expertise and necessitate ongoing attention.
- **School support**—The involvement and commitment of the host school are other critical elements that necessitate both initial and ongoing attention. The politics and diplomacy required for the operation of student assistance programs must be applied to a program area that is likely to be associated with greater stigma and to encounter more resistance. Alternative school settings appear to be the most readily acceptable locations.
- **Prevention and intervention staff involvement**—If different personnel deliver the prevention and intervention services and the treatment services, strong links must be formed between these services. One cannot assume that these links will occur naturally, and without them the promise of school-based treatment will be only partially realized. If the staffing is combined the administration must deal with the need to hire and train staff who are equally comfortable and competent in both roles. To neglect this directive is to ensure that one or the either halves of the dual role will be neglected or carried out poorly.
- **Funding**—Treatment services must be supported by different funding than that used for the Prevention and Intervention Services Program services. Thus the district or ESD must develop and maintain new funding sources, all of which generally impose

their own requirements for paperwork and performance. Successful efforts maximize their ability to draw from multiple funding sources. Only in this way can one generate enough resources to sustain services and ensure that all students will be served regardless of their ability to pay.

- **Critical mass**—The efficient delivery of treatment services in a group setting requires some minimum number of students and sufficient staff time on-site. Too few students render the model for delivery inefficient and perhaps ineffective. Treatment services cannot effect optimal outcomes if staff spend only a few hours a week on campus.

Perhaps because of the complexity and interrelationships of these requirements, the promise of improved access and availability to substance abuse treatment is only partially realized in the existing school-based substance abuse treatment programs in Washington. In some cases school-based outpatient treatment for adolescents remains concentrated primarily in larger population centers in a few locations. Thus the distribution of these services does not differ greatly from that of community-based services, and treatment services are still relatively uncommon in smaller rural schools. ESD 113 is providing such services, but the demand for services in the smaller school sites is not always sufficient to form a cohort for service delivery. ESD 114 offered treatment services in rural areas in the past, but these services were not cost effective and the county withdrew funding support. Clearly, the risk of failure is associated with this innovation.

Only schools that offer substance abuse treatment services when school is in session truly improve access to treatment. The current pattern of treatment service means that even with school-based delivery, some youth continue to encounter such barriers to access as a lack of transportation. School-based treatment is likely to lessens the severity of these constraints in smaller communities. In more populous locales where other treatment providers are available, the circumstances for accessing treatment are often little altered. The greatest service improvements have benefited middle school students involved in the ESD 113 program. These students have access to age-appropriate outpatient treatment services that they were unlikely to have had in the past, and all such treatment for younger teens is delivered during the school day.

The evidence of improvements in treatment quality and effectiveness with school-based delivery is limited but promising. Schools can and do have more control over the content and delivery of treatment services, and, if nothing else, school-based treatment services are likely to better fit with other school services than community-based treatment services.

Some evidence indicates that when students are referred to school-based treatment services they are more likely to engage in treatment. With combined staffing or good staff interrelationships, students' progress is more closely followed and integrated with prevention, early intervention, and other school services. Less evidence indicates that school-based treatment improves retention. One program in Washington has been handicapped by the school granting credit for only part of the hours required for treatment completion: students attend as long as they receive credits, but attendance drops off when this incentive is removed.

School-based substance abuse treatment may have advantages in addition to availability, quality, and effectiveness. The presence of substance abuse treatment services on the school campus contributes to a greater sense of ownership among school staff and recognition of the need for and value of substance abuse services on campus. Delivering outpatient substance abuse treatment services to adolescents on the school campus underscores the message that adolescent substance abuse is a legitimate focus of schools. This sentiment is likely to benefit regular prevention and early intervention services and services for youth needing more intensive intervention.

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Appendix: Methodology

Information on existing school-based treatment programs was collected through telephone interviews with providers of Washington State’s most extensive school-based substance abuse treatment programs—ESD 114 and ESD 113—and with several representatives of smaller scale services offered through community-based providers in Federal Way, North Kitsap County, and Yakima County. These interviews covered descriptive information about current services and sought insights on strengths and weaknesses in practice and for the general model. Interview data also came from Prevention and Intervention Services Program administrators, who were identified as interested in examining this approach to services. Questions for these individuals focused strategies and rationales for consideration of school-based treatment delivery.

Information on state requirements and concerns was collected from the individual responsible for adolescent treatment at the state’s Division of Alcohol and Substance Abuse. A county substance abuse coordinator and a former treatment provider who were involved with the state’s first such program at ESD 114 provided information on implementation, operations, and changes over time. John Hughes, presently the Program Supervisor, Safe and Drug-Free Schools, Office of Superintendent of Public Instruction, initiated this program and also provided historical information and insights about the development of this approach and the present circumstances of school-based treatment.

The agencies currently delivering or contracting for school-based treatment that contributed to this paper included:

- Cascade Recovery, Silverdale; contact person: Steve Baylock.
- Dependency Health Services, Yakima; contact person: Michelle Cadigan.
- ESD 113, Olympia; contact person: Rob Vincent.
- Federal Way Youth and Family Services; contact person: Andrea Frost.
- ESD 114, Bremerton; contact person: Awelda Jesionowski.