

Recovery Schools for Delaware Need and Feasibility Assessment

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1. We looked at the potential need for treatment among Delaware youth and young adults

Data from the school surveys, treatment at DSCYF and DSAMH, and Medicaid claims were examined for incidence and treatment. All showed that incidence was NOT geographically concentrated. Cases were proportionate to the overall population by County, so there is not an indication that this was a Sussex County problem or a Wilmington problem where services would need to be focused. The data do show:

- a. Opioid involvement requiring treatment is small though by no means nonexistent for the high school age population, but it is much higher in the young adult population**
- b. The drug of abuse for high school age youth is predominantly marijuana, with still a substantial number meeting criteria for treatment for alcohol**

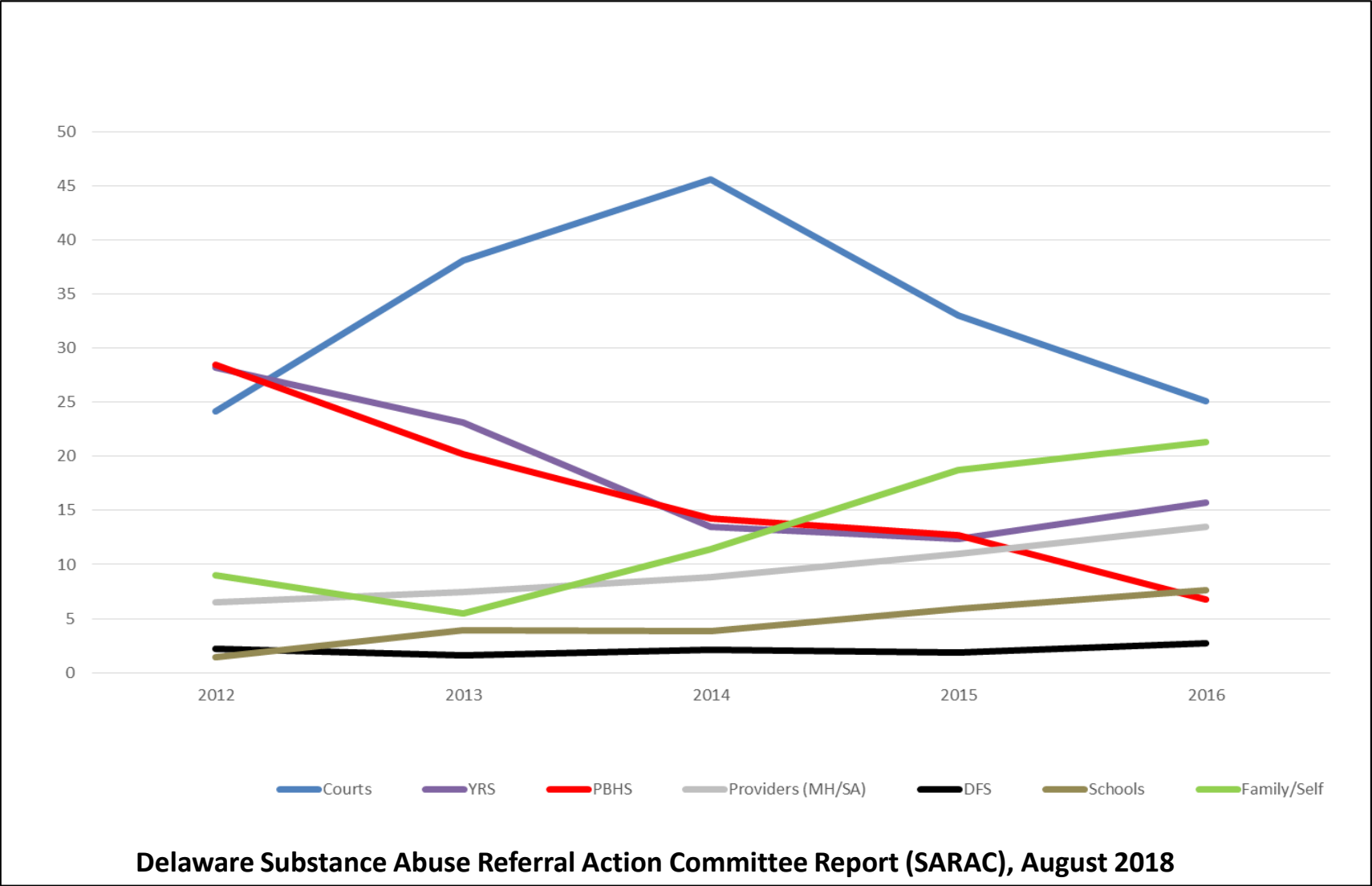
Types of Substance Use Disorder (SUD) of Medicaid Clients by Age Group FY2017*

Type of SUD	FY 2017					
	Age Cohort					
	15-17		18-20		21-24	
	#	%	#	%	#	%
Alcohol	131	25%	172	23%	439	25%
Opioid	20	4%	133	18%	895	52%
Cannabis	419	80%	555	75%	886	51%
Other	54	10%	69	9%	223	13%
Total in Age Cohort	526		743		1736	
<ul style="list-style-type: none"> Types of SUD sum to more than 100% as many clients had more than one type of SUD <p><i>Medicaid data provided by the Delaware Division of Medicaid & Medical Assistance through a partnership with the University's Colleges of Arts & Sciences</i></p>						

We looked at other indicators of youth and young adults with diagnoses of substance use disorder and receiving treatment

- a. School survey data and patterns of substance use disorder by age in the Medicaid data show marijuana is a precursor to opioid abuse among many youth and young adults; but both DPBHS and DSAMH data suggest that treatment for marijuana use has declined for both youth and young adults. DSAMH data for adults show the decline of marijuana as the primary drug of admission declined from 1161 admissions in 2012 to 470 in 2016.**
- b. Declines in referrals to youth substance abuse in DPBHS seem due primarily to a reduction in court referrals which had previously been for marijuana but now seem less of a focus for law enforcement, leading to fewer youth identified as needing treatment through state sources.**

Distribution of all Youth (<18) Referrals Received by Aquila 2012-2016



CONCLUSIONS AS TO **NEED**:

- School survey data and the Medicaid data suggest more youth and young adults have been diagnosed with or are getting treatment for substance abuse than had recently been thought. There has not been a decline in youth using drugs or in treatment in Delaware; it has at least been stable for youth and, for young adults, it has likely increased. Changes in marijuana laws and attitudes and the use of Medicaid rather than direct state services partially hid these patterns.
- School surveys suggest that there at least 800 Delaware high school students meeting criteria for dependence on alcohol, marijuana, or other drug. And even with considerable overlap between the school survey, and the treatment data, there are about 500 high school age students (15-17) who have received a diagnosis of or treatment services for some substance abuse issue in the past year. If programming is being considered for young adults, the estimate for those with a diagnosis or treatment services is about 700 for those 18-20, and about 1500 for those 21-24.
- These numbers and the personal accounts from clients and families we talked with indicate a small but real acute need for services for a few youth and many more young adults with opioid substance use disorder. They also indicate a much larger need for services for youth dealing with marijuana and alcohol disorders that has received less attention in the midst of the opioid epidemic.

2. We examined RHSs nationally, and report on their programs, promise, practices, and problems

Characteristics of RHSs in the Association of Recovery Schools

First was in 1987 in Minnesota

Slow growth with 15 schools in the 1990s, 31 schools in 2008, and 40 in 2015 in 15 states

Since 2015, the number of RHSs has declined to 34 or fewer

Average enrollment 23
Range from 6 to 73

Student to Staff ratios vary from 2.5 to 1 to 12 to 1

Only 1 published outcome evaluation: showed reduced marijuana use and a few days less absenteeism

Observations about Recovery High Schools

- a. RHSs are expensive to operate with high costs per student.
- b. Even urban schools have transportation issues, and all struggle with student's means and motivation to get to school.
- c. In many RHSs, education is only core curriculum and uses mostly online courses with limited teacher contact, few extra-curricular options, and limited interaction with other students.
- d. Most schools have small enrollments, often less than anticipated, and struggle to maintain enthusiasm and students after the start up years.
- e. Financial stability is a constant issue, and RHSs scramble to maintain district and state funding and most must raise additional funds.

Conclusions:

- 1. The review of most of the existing RHSs shows great enthusiasm among those running the schools but significant operational roadblocks, which have led some RHSs to close; and**
- 2. Research found the only drug reduction effect was for marijuana (not other drugs), and even the best RHSs have issues of relapse and levels of drug use more than found in comparable public schools.**

3. We looked at what resources (champions, federal state and local instrumental support) and barriers (cost, location, logistics, sustainability) there are to establishing and maintaining programs in Delaware?

- a. Transportation in a state with limited urban areas and available public transportation
- b. Questions such as should clients have to have previous treatment, be of high school age and not older, not be adjudicated, and should the program have a zero tolerance for relapse
- c. Meeting both federal and state educational and health mandates for school and health facilities would be difficult in a small retrofitted facility
- d. Even many of the early proponents of a physical RHS in Delaware now recognize the logistical and other difficulties of a RHS.

Conclusion: A Recovery High School is an institution for supporting youth who have been in treatment and who need continuing care in their recovery with a specialized goal to continuing their education. Delaware has youth with these needs, but providing comprehensive services for a meaningful number of youth in one or two or even three locations would have financial and political limitations.

4. We examined alternatives to be considered by the BHC, community champions, and other policy makers in Delaware to provide needed services for the dual goals of recovery and education.

Promising options to consider include:

- a. Integrate a recovery support track in existing schools
- b. Expand use of IEPs and 504 plans (while hiring more psychologists, teachers, and support staff to design and implement individual plans)
- c. Hire recovery coaches to work with students as they return to school
- d. As opposed to RHSs, Collegiate Recovery Communities have been more successful and growing. Delaware should consider developing a collegiate recovery community approach for young adults coming back to school, perhaps at Delaware Technical Community College.

A RHS could be a piece of the puzzle needed for a continuum of treatment services, but only a piece. It could be very helpful to a very few, but logistics and location would be complicated. Other options could provide resources to youth and families in all parts of the state. We believe it would be better for Delaware to invest its resources into increasing supports for recovering students in existing schools and communities using not just one strategy and/or one facility.

Overall Conclusions and Recommendations

- 1. Better assessment of student, youth and young adult needs; greater use of existing instruments can help identify better modalities of treatment and services needed for each individual;**
- 2. New education programs to tell youth, young adults and families about drugs and where they can go for treatment and new education programs in schools and communities to help reduce the stigma of drug use and the labeling and shaming that can go on;**
- 3. More support, particularly downstate, for mental health and substance youth professionals trained in trauma informed care to work with youth, perhaps on the DSCYF behavioral health consultants model; this needs to include training in use of evidence based practices;**
- 4. Planning for a youth and young adult continuum of care leveraging existing resources and champions and identifying gaps and solutions to fill in the continuum, planning to include community champions;**
- 5. Operationalize key elements of the recovery school model within existing educational resources statewide;**
- 6. Evaluation on an ongoing basis of any new or expanded programming put into place.**