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Continuing Care in High Schools: A Descriptive Study of Recovery High School Programs

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Abstract

Data from 17 recovery high schools suggest programs are dynamic and vary in enrollment, fiscal stability, governance, staffing, and organizational structure. Schools struggle with enrollment, funding, lack of primary treatment accessibility, academic rigor, and institutional support. Still, for adolescents having received treatment for substance abuse, recovery schools appear to successfully function as continuing care providers reinforcing and sustaining therapeutic benefits gained from treatment. Small size and therapeutic programming allow for a potentially broader continuum of services than currently exists in most of the schools. Recovery schools thus provide a useful design for continuing care warranting further study and policy support.

High schools specifically designed for students recovering from a substance use disorder (substance abuse or dependence) have been emerging as a continuing care resource since 1987. The 2010 National Drug Control Strategy supports this approach and calls for “the expansion of community-based recovery support programs, including recovery schools, peer-led programs, mutual help groups, and recovery support centers” to assist students in their efforts towards continued sobriety. In recent years, there have been an increasing number of studies on post-treatment continuing care for adolescents (e.g., Brown, 2004; M. D. Godley, S. H. Godley, Dennis, Funk, & Passetti, 2002; S. H. Godley et al., 2010; Kaminer, Burleson, & Burke, 2008; Moberg & Finch, 2008). Studies on recovery high schools have been limited to theses and dissertations (Doyle, 1999; Finch, 2003; Rubin, 2002; Teas, 1998), single site evaluations (Diehl, 2002), preliminary feasibility studies (Moberg & Finch, 2008) and unpublished evaluation reports (Moberg, 1999; Moberg & Thaler, 1995).

Despite the lack of scientifically rigorous evidence of their effectiveness, recovery high schools have garnered national attention through media such as CNN and NBC, the Robert Wood Johnson Foundation (Diehl, 2002), and federal offices such as the Office of National Drug Control Policy (ONDCP) and the Substance Abuse and Mental Health Services Administration (SAMHSA). This attention and a modest advocacy effort led by a professional association (the Association of Recovery Schools) has helped recovery high schools garner support and anecdotal evidence of success, prompting a rapid expansion of programs - most of the schools have opened in the last 10 years (White & Finch, 2006). As recovery schools generate awareness, and more states and foundations consider funding

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such schools, systematic research that describes and explicates school models is needed to inform replication. This study of 17 schools provides the first systematic description of recovery school programs and their students. The primary goal of this paper is to describe the differences and similarities among the existing recovery high schools in the U.S. and to discuss emergent challenges for the sustainability and expansion of these programs.

Background

According to 2008 estimates from the Monitoring the Future study, approximately 30% of 8th–12th graders have used illicit drugs, 15% have used an illicit drug in the past month, and 15% have been drunk in the past month (Johnston, O'Malley, Bachman, & Schulenberg, 2009). Longitudinal studies indicate that substance use during adolescence is associated with poor academic performance, drop-out, and lower college attendance (Fergusson, Beautrais, & Horwood, 2002; Fergusson & Boden, 2008; King, Meehan, Trim, & Chassin, 2006; Lynskey & Hall, 2000). Substance use disorders (SUDs) led approximately 143,000 high school students to receive treatment for drug or alcohol problems in 2009. This represents about 7-percent of children age 12–17 with SUDs (Substance Abuse and Mental Health Services Administration, 2010).

Treatment does consistently yield reduced substance use (Tanner-Smith, Lipsey, & Wilson, 2010; Tripoldi, Bender, Litschge, & Vaughn, 2010). However, 35–75% of all teens use (relapse) after leaving treatment (Tomlinson, Brown, & Abrantes, 2004) and 47% of all students returning to traditional high schools resume full-blown drug use within one year (Winters, Stinchfield, Opland, Weller, & Latimer, 2000). While some of this can be attributed to the quality of the treatment program and to the chronic relapsing nature of SUD's, much can be attributed to the environmental factors in place *after treatment* (M. D. Godley et al., 2002). Once students have made a decision to stop using alcohol and drugs, i.e., to begin "recovery", continuing care and support services have long been seen as an "essential" component of the treatment continuum (Brown, 2004; Donovan, 1998; M. D. Godley et al., 2002; Kelly, Myers, & Brown, 2000; Marlatt, 1985). Winters (1999, p. 24) suggests that for adolescents, "the period right after completion of a treatment program, when the youth returns to family, peers, and the neighborhood, is often the time of greatest risk of relapse." Spear and Skala (1995, p. 346) concur that the first 60 days are "the greatest time of risk for each level of relapse", suggesting "the need for intense post-treatment services during this time".

Adolescents and young adults develop their identities through peer connection and interaction. Once a young person has decided to stop using alcohol or drugs, the people with whom they interact and the support systems available will play a major role in determining their success. Schools provide a major, if not the main, system of peer interaction and support for adolescents and young adults. During the particularly fragile period after treatment, school is a critically important social environment for adolescents with SUDs. Indeed, school sits at the heart of the threat of relapse and other unhealthy and maladaptive behaviors for these students.

On the other hand, schools are opportunities for the promotion of recovery. They can potentially play an important protective role for students given that school bonding, school interest, and academic achievement are negatively associated with substance use among high school students, particularly among low-achieving students (Bryant, Schulenberg, O'Malley, Bachman, & Johnston, 2003). Succeeding academically can help students stay sober, which in turn can help them graduate (Gibson, 1997). Involvement in prosocial activities at school can assist the recovering person (Vaillant, 1988) and "connectedness with school" has been shown to be a general protective factor for adolescents (Resnick et al.,

1997). Recovery schools uniquely serve this purpose by establishing a community commitment to sobriety and re-engaging students with SUDs in the educational process.

Most past research regarding recovery schools has examined single programs, emphasizing initial implementation, feasibility and institutionalization, as well as micro-level interaction patterns within a school. The small body of research conducted to date suggests that recovery high schools are feasible to implement and sustain. Moberg and Thaler (1995; see also Diehl, 2002) studied the Albuquerque Recovery High School (ARHS), the first known study of a recovery high school, focusing on the feasibility and replicability of the program model and its institutionalization into the Albuquerque Public Schools and community. They concluded that the ARHS model was feasible programmatically, with impressive evidence of therapeutic support for students but more limited educational support. No scientifically rigorous outcome studies of recovery schools have been conducted to date.

Methods

The present study was conducted as an exploratory, descriptive analysis with the goal of yielding a typology of the schools and their operative program theories/models. The study included a one-day site visit to each of 17 participating schools during which surveys of students and staff were conducted, along with intensive interviews with staff and general observations of the sites. Data collection occurred over three school semesters.

Sample

Our sample was 18 high schools (17 research sites and one pilot) that generally fit the Association of Recovery Schools (ARS) defining criteria (see recoveryschools.org) and, to assure some degree of stability, that had been operating for at least two years. Five participant schools and the pilot school were not members of ARS at the time of data collection, enabling us to explore a broader range of “recovery” schools.

The recovery high schools selected as research sites were in the following states (number of schools in parentheses): California (3); Colorado (1); Minnesota (8); Pennsylvania (1); Tennessee (1); Texas (3). The sample approximated the national distribution of schools, with Minnesota, California, and Texas being the only states with more than one school in operation more than two years at the time of the site visits. Minnesota had at least 10 recovery high schools.

Site Visits and Data Collection

Data collected included observational field notes, tape recorded staff interviews, documents (school charters, policy manuals, student handbooks, websites, and accountability reports), anonymous surveys of students, staff and administrators, and secondary data such as school administrative data, attendance reports, graduation rates, and other reports available from the schools. Site visits facilitated collection of survey data but also complemented and extended that data by allowing for exploration of the school and community, direct observation of settings and activities, and access to key individuals for interviewing. Site visits were typically conducted by teams of two-or-three researchers (in two cases, only one researcher visited due to the extremely small size of the schools), in order to allow for multiple insights, differential expertise, cross-validation of findings, and enhanced scope. Increased validity of results was facilitated by this team approach. Due to IRB concerns regarding protection of human subjects, students were not interviewed.

Interviews

As the purpose of the site visits was to gather descriptive information about the programs and students rather than to carry out a complete naturalistic inquiry or case study, we conducted scheduled, relatively standardized oral interviews (LeCompte, Preissle, & Tesch, 1993) with administrators, teachers, counselors, and other key personnel, such as volunteers or Board Members. We also attempted to interview at least one external constituent from each school's inter-organizational network (such as school district administrators and referring treatment providers.) Interviewees were chosen based on discussions with school leaders and accessibility on the day of the site visit; a total of 61 interviews were completed.

The interviews used detailed interview guides (tailored to the type of respondent) to assure that all of the conceptual areas of interest were covered at each site. While the interview guide provided structure, probes and exploration of relevant divergent topics were also incorporated to maximize the learning from these interviews. With written permission of the participants, interviews were recorded and subsequently transcribed and erased.

Surveys

In each school, staff, students, and the responsible administrator were asked to complete a survey which summarized information about the school program itself. Administrator (n=17) items focused on the organizational and physical structure of the school, number and characteristics of students, number and characteristics of staff, testing and employment policies, and other related items. A number of these items were adapted from the National Center for Education Statistics' annual Schools and Staffing Survey (U.S. Department of Education, 2004). Staff (n=75) items included information specifically about their own demographic background, training, credentials and attitudes regarding education and recovery. Included in the staff survey were a series of attitudinal questions regarding operational aspects of the recovery school. Finally, an anonymous survey was developed for students (n=320) to complete during the site visit. Results from this survey are reported elsewhere (Moberg & Finch, 2008). While the student surveys offered intriguing insights with regards to student-level outcomes, this article will describe school-level characteristics.[1]

Analysis

This paper's analysis describes recovery high schools in terms of the differences and similarities among schools. The analysis focused upon educational and therapeutic services, funding, school goals, student characteristics, and access to the programs. Interpreting how participant schools approached recovery support was a central goal of the study.

Survey data from administrators were used to summarize key structural aspects of the schools. Interview data and observations were used to better understand the operation and dynamics of the schools. Linkage of the student-level data with coded summary categories of programs – or key program variables – which emerged from the school-level analysis allowed us to tentatively address questions of how student characteristics and opinions were related to the inter-organizational structure, funding system, and institutionalization of the schools.

[1]While not the focus of this article, retrospective pretest to post-test analysis suggested significant reduction in substance use as well as in mental health symptoms among the students in recovery schools. Students and staff were very positive in their assessment of the therapeutic value of the schools, and the data suggested positive but less enthusiastic ratings of the academic programs. The school programs do appear to successfully function as continuing care to reinforce and sustain the benefits students gained from their treatment experiences.

Data interpretation followed approaches to interpreting data from education settings as summarized by Hatch (2002, p. 57). Interview data were transcribed, with verbatim faithfulness to the words of the interviewee, and the narratives were eventually read independently by two different analysts. One reviewer was familiar with recovery schools (AJF), and the other was introduced to them in large part by this study (ALK). Data were then coded according to topics using qualitative analysis software (QSR-NUDIST, version 6). Non-examples or negative cases were also noted to determine if the data ultimately supported the identified patterns. Relationships among those patterns were then identified, and data excerpts were selected to support or illustrate generalizations. Main ideas emerging from those markings were recorded, and patterns, categories, and relationships were highlighted.

Analysis of the structured interviews and site visit observations expanded upon the data gathered in surveys, assessing the extent to which participants shared beliefs or schools shared certain constructs, triangulating against the survey data (LeCompte et al., 1993). One component of this analysis was to assess school staff's understanding of the logic of their programs—i.e., the testable assumptions which link presenting problems of students, the program interventions, and the proximal, intermediate and long-term outcomes expected for students (e.g., Wholey, 1987). This process essentially attempted to extract staff's operative program theories (logic models) from the data, which was especially important considering the lack of extant literature on recovery high schools.

Findings

Identity of Recovery Schools

While for descriptive purposes this article uses the term "recovery high schools"– in line with the language of the Association of Recovery Schools – the programs themselves use a number of titles. In keeping with frequent embedding of recovery schools in larger organizations, some participants referred to the schools as "programs" rather than "schools", even though the school had its own staff and student base. Others referred to their school as a "sober school", "alternative school", "community school", "charter school", or "area learning center (terminology school unique to Minnesota).

Organizational and Physical Structure

The organizational structure of the recovery schools encompassed many different forms, including charter schools and/or programs embedded within them, alternative schools and/or programs embedded within them, programs contracted by the public school system, and a private school. Twelve schools shared space with another school or a non-academic organization, and five resided in their own separate space, which was either a free-standing building or in the case of one school, a portable facility. Of the 12 schools that occupied space within another building, nine of them resided in a structure with at least one other school program, including six that were embedded organizationally with the other school. Two schools resided in leased or donated buildings that did not include educational programs (one was a church basement) and one additional school was housed within a treatment facility.

The schools that were embedded within another school cited significant benefits to that arrangement. They were able to keep operation costs lower because they shared a building and staff members with an existing school. Being a part of a larger school also enabled the recovery programs to offer classes they would not otherwise have been able to afford, such as art and physical education classes, and often provided recreational space that the recovery students could use. All but one of the embedded schools, however, had at least one staff member dedicated solely to the recovery school program.

The primary concern for recovery schools located within close proximity to another school was that their students were in a precarious state of recovery and could be negatively affected by exposure to students not in recovery as well as potential drug and alcohol use and/or distribution occurring within the other school programs. The schools thus used a combination of physical barriers and staggered scheduling to limit the interaction between students. One school originally had recovery students move as a group to each classroom, but found that arrangement was not sufficient to protect their students because the students felt their recovery was “not safe” because they were offered substances during their brief interactions in the hallways. Whether recovery schools had their own separate building or created a distinct location within another school or organization, all staff members stressed the importance of recovery students having their own separate space. Separation created a sense of peer-related security for students, but it also encouraged students to begin to take ownership of their school and their education.

Enrollment Size

Recovery schools had varied enrollment, ranging from 6 to 50 students, with an average of 24.5 students. By comparison, the U.S. Department of Education National Center for Education Statistics (NCES) reported a mean of 90.8 students enrolled in the 6,207 U.S. alternative schools in the 2008–09 school year (Hoffman, 2010). In our sample, six schools had an enrollment of 15 students or less, six schools had an enrollment between 15 and 29 students, and five schools had an enrollment of 30 students or more.

The attendance observed during site visits was significantly less than the number of students enrolled (on average 65% of the official number). This discrepancy could be due to any number of factors, including truancy problems, but the dominant factor is most likely the high turnover of students. Many schools see enrollment changes daily, and most others have regular turnover of students weekly to semi-weekly. Based on the administrators’ surveys, turnover is such that the total number of students enrolled in the fall official enrollment count is estimated to be 45% of the total number of students who enroll over the course of the school year.

Enrollment depended on numerous factors, including access to eligible students, funding, and school mission and focus. According to interview data, 10 schools would have preferred to have a larger enrollment, but obstacles existed to expanding enrollment, including a scarcity of students meeting schools’ eligibility criteria, limited referral options in their community, lack of connections with community organizations, and/or limited transportation options for students.

Funding was a major consideration in establishing a school’s capacity. All schools recognized that they needed to enroll a larger number of students in order to be financially viable. Schools with larger capacities did not need to rely as much on outside funding because their higher student enrollment provided them with a larger source of income for a similar number of staff members.

School mission and focus also shaped the desired capacity of the schools, and thus their enrollment. Schools with a lower desired capacity, such as 15 students or less, felt strongly that a smaller student body was important for meeting the therapeutic needs of their students and maintaining the sense of community and mutual support. Those schools with a lower desired capacity tended to have objectives for students that were more therapeutic than academic in nature. The five schools with the largest enrollment (30 or more students) tended to have a greater focus on academics than on therapeutics, and tended to hold their students to higher academic standards.

Regardless of the size of the school, all but two schools struggled to reach their enrollment goals. This was problematic for three reasons. First, the schools' staff and resources were budgeted based on funding received for a specified number of students. A lower than expected enrollment thus put *extreme financial pressure* on the organization. Second, when schools did not have a waiting list of students wanting to attend, they felt the *need to broaden their eligibility requirements* in order to reach their desired capacity. As one counselor put it, "The more kids we have coming in the door, the stricter we can be with our rules … what you have to do to be here." The third reason why a lack of a steady source of students was troublesome for recovery schools was because the staff members then *did not feel as capable of releasing students that did not meet the schools' requirements* because of their need to maintain a certain level of financial stability.

Staff Description

Teachers—The staff composition at the study schools varied depending on one or more factors, including the school's mission, operating budget, and/or whether or not the school was affiliated with another school. The teaching staff ranged from 1–5 teachers. Six schools had only one full-time teacher that administered the entire curriculum. Teachers at three of those schools utilized a computer-based curriculum for all or some of the subjects. Of the six schools that were embedded organizationally within another school, four did not have their own teachers and instead shared the teachers from the umbrella school. Two schools had two teachers and five schools had 3–4 teachers.

Counselors—Although therapy was a designated component of the study schools, students' access to counseling staff varied greatly across the schools. For purposes of this discussion, anyone who was a licensed counselor, therapist or psychologist is considered a counselor. Five schools had 2–3 counselors on staff. Two of those schools had one designated counselor, plus one or more teachers or an administrator that were also licensed as counselors and served in that role. Five schools had one counselor on staff and three schools had an administrator that was licensed and served as the school counselor. Four schools had no counselor on staff, but two of those schools enabled students to book time with outside counseling contractors.

Funding Sources

The study schools were funded by a variety of methods, including public education funding, private donations, grants, and financial partnerships. The majority of all schools' funding was tied to per pupil enrollment. Fifteen schools received public funds via the state, district, or an individual school. Two schools required tuition payments from enrolled students. All but one school also required additional funds and in-kind contributions to subsidize their programs. These funds were secured through donations, grants, and partnerships in which an outside organization donated school space or staff. The median amount of public or tax-based funding was 80 percent, and eight schools reported receiving 75–100 percent of the revenue from public sources. The two most common public school funding categories were alternative schools/area learning centers (9) and charter schools (5).

Funding was a primary challenge for all of the schools in this study, regardless of their organizational structure and size, especially because most schools required outside financial assistance in order to operate. Philanthropic donations, grants and financial partnerships were unreliable because of the changing goals and economic statuses of the donors. In addition, public funding was not always guaranteed for those schools with associations with the public school system because all of the schools and programs could be cut or terminated due to administrative, political, or financial changes.

Student Referral Sources

Other than self, family, and peer referrals, treatment centers, other high schools, and juvenile justice centers provided the majority of students to the study schools (see Figure 1). The schools' ability to create and maintain relationships with a sufficient number of these referral sources and/or a particularly close relationship with one regular and reliable source of referrals was critical to their success. Whether a school received public funds based on pupil attendance or private tuition from each student enrolled, funding tied to pupils provided schools with the majority, if not all, of their operating budget.

Although the schools were created in order to respond to a perceived need in their community, most schools found it difficult to recruit an adequate number of students, or at least an adequate number of students who were truly committed to recovery, in order to remain financially viable. "Getting enough students" was voiced as one of the primary challenges for 15 of the 17 schools. Access to eligible students was limited for a number of reasons, including a dearth of treatment facilities, unproductive or nonexistent relationships with referral sources, and competition for students, among others. In some cases, local schools were hesitant to refer students who might benefit from a recovery high school placement because the home school would lose the per pupil allocation by doing so. The ability to establish relationships with one or more referral sources depended on the presence of such facilities in the proximate community, their openness to sending students to the recovery schools, and the staff's time, ability and efforts to establish and maintain relationships with the referral sources. A review of the schools' referral sources revealed that only six of the 17 schools received regular referrals of students from multiple sources. An abundance of potential students gave schools the ability to be more selective in which students they accept, and thus the presence of varied referral sources could also allow the staff more control over the mission and programs of the schools.

The types of referrals, as well as the number and quality of referral sources, played a role in shaping the philosophical and organizational structure of some schools. Schools that received students straight from a treatment facility were essentially guaranteed students with a period of sobriety and some prior knowledge about substance use dependence, and thus could focus their attention on providing quality academic programs for the students. Schools that had difficulty identifying or recruiting students with prior treatment experience, particularly those schools that had few or no treatment providers in the area, often had to broaden their eligibility requirements and/or offer more in-depth treatment services that cut into academic time.

Students

Regardless of the referral source for students, all schools attempted to apply some standards for admission that helped them identify those students that were most likely to benefit from and succeed in the recovery school environment. The students in the recovery high schools studied slightly overrepresented male students (54%), were predominantly white (78%), with about one-half from two parent homes. Overall parent educational levels suggest a higher mean SES than in the general population.

Students came with a broad and complex range of mental health issues, traumatic experiences, drug use patterns, criminal justice involvement, and educational backgrounds. Most, though not all, students (78%) had prior formal treatment for SUDs, often concomitantly with treatment for mental health concerns, and were often referred by treatment providers. All schools in this study were selected based on their assertion that their school was designed for students in recovery from a SUD. However, in relation to the "stages of change" model (DiClemente, Schlundt, & Gemmell, 2004; Prochaska,

DiClemente, & Norcross, 1992), schools admitted students anywhere from contemplation through active recovery maintenance because schools often had limited referral source options, or they had limited time to tap into those resources.

The explicit mission of 15 of the schools was to serve students who were in some stage of recovery and had recognized that substance abuse was negatively affecting their lives. In practice, however, many of these schools also served students who, in the staff people's minds, were not yet diagnosable as having a SUD, "hadn't yet gotten in enough trouble to take recovery seriously," or were not "even interested in being sober." Various factors may have contributed to this incongruity between the mission and practice of the schools. First, it was *difficult for staff members to ascertain where a student was in his or her recovery*, even after intensive interviews and written statements by the students. Second, schools often *did not have a large or consistent enough referral base* to limit their enrollment to just those students in active recovery. For example, many schools did not have access to treatment centers and thus recruited students from the public school system and the juvenile justice system in which many students did not have prior treatment experience and were not yet committed to "recovery." In addition, three charter schools in Minnesota cited state *laws that prohibited them from setting entrance requirements*, although they worded the student entrance contracts in such a way that only those students committed to abstinence and willing to work the treatment program would be inclined to enroll.

Schools employed various methods to screen for students interested in pursuing abstinence and a program of recovery, such as culling for student "willingness" to abide by the school contract, requiring some period of student sobriety immediately prior to enrollment, and accepting only those students with a formal diagnosis of SUD and/or prior treatment experience. Most schools required students to sign a contract that, in addition to a commitment to abstaining from drugs and alcohol and an agreement to submit to random urinalysis, often required students to attend outside support group meetings and/or secure a sponsor. Willingness was determined through in-depth interviews with prospective students that included discussion of prior use and reasons for wanting to attend a recovery school, written statements by the students describing why they wanted to be abstinent, and occasional corroborating evidence of such commitment from one or more non-family members. Most schools acknowledged that very few students were turned away. Those that were denied access included students that readily acknowledged they were going to continue to use substances, those that refused to sign the contract, or those with severe psychiatric disorders that the schools felt ill-equipped to handle.

Honesty—A common requirement at many schools, although not stated explicitly in most of the contracts, was that students were to be honest – with each other, with staff members, and particularly in relation to relapses. As one administrator said,

> "My kids know that in the recovery world there is a sense of honesty. There is an honesty policy that I have in the program … They are definitely going to know that they messed up by being dishonest. And it wasn't that they relapsed, it was the lie about it."

If a student broke the initial contract (usually by relapsing), so long as the student appeared to maintain willingness and honesty, a new contract was drafted with more stringent requirements, thus giving some students multiple chances to comply with the program expectations. Although most contracts required such things as group therapy participation, personal recovery plan execution, attendance at outside AA/NA meetings and securing of a sponsor, schools appeared to only dismiss students who repeatedly violated the sobriety portion of the contract or who solicited other students to participate in substance use.

Length of Sobriety—One way in which schools could filter students in an effort to identify those who were truly interested in recovery was by requiring a stated number of days with continuous sobriety prior to admittance. Most schools identified a prior 30 day period of sobriety before admittance as ideal, but due to lack of referral sources, funding requirements, and laws governing charter school admittance requirements, only four schools absolutely required students to have at least 30 days continuous sobriety. Those schools requiring 30 days sobriety tended to be schools with varied and consistent referral sources. They were thus able to have more strict requirements due to an increased access to potentially eligible students.

Prior Treatment—Only five of the schools required students to have participated in or completed prior treatment for substance abuse. While the 12 other schools did not require students to have prior treatment, four of them did occasionally require students to attend outpatient treatment concurrently with their schooling. One administrator noted how "most of the ones that were relapsing were the ones that had never been in counseling or treatment before."

Academics

There was no identifiable model that shaped and guided the academic programs at the schools, though as regionally-accredited and/or state "approved" schools, they were all required to meet at least minimal academic standards. All schools were committed to educating their students and to helping students "catch up" academically when needed, but the structure, goals, and quality of the programs varied greatly by school.

Program Structures—Class sizes and structure often depended on the quantity of students and their needs at any particular time. These variables changed frequently due to the high turnover of students in the recovery schools. Class sizes ranged from two or three students up to 15 students in a class. Classes were organized based on grade level(s), ability level, credits needed to graduate, or in the case of smaller schools, all students were taught the same subject matter or were working on multiple subjects with one teacher at the same time. Students were taught either by one teacher for all subjects, one teacher for each subject, or they followed a cyber-based curriculum during which time a teacher would provide individual attention to the students as they worked through the material at their own pace.

School Academic Goals—Schools that preferred students *stay and graduate* from their program had students that stayed from one to four years, depending on when they enrolled. The six schools that aimed to have students graduate from their program believed that having students remain in the recovery school for as long as possible was the best approach to getting and keeping kids sober, as well as to prepare them to transition away from the school's support, usually into post-secondary education. Schools that intended on having students remain and graduate from their program tended to have a school that was separated from other educational programs and had higher academic standards for their students than schools with students' transition as their primary goal.

Schools that aimed to have students *transition back to a traditional high school* requested students stay for a period of six months to a year, although some students stayed longer. Staff members at the five schools where students were expected to transition back to a traditional high school after a period of time tended to feel strongly about the importance of returning students to "real life".

Schools that gave students the *choice of staying or transitioning back* had students staying for anywhere from six months to four years. The six schools that allowed students to either remain or transition back to a traditional school decided to leave the choice up to the students and/or their parents. Their general perspective was that the two most important goals of the schools were to get students sober and to help them get a high school diploma. They supported whichever avenue worked best for each individual student.

Academic Quality and Rigor—All schools strove to provide an academic program that would enable students to at least catch up academically and ultimately *secure* a diploma. According to school staff members, however, the quality of their academic programs ranged from "weak" to "very, very rigorous". These discrepancies were cited as resulting from differences in fundamental ideas about where primary attention should be paid, either in academics or therapeutic services, as well from varying levels of resources and staff training, student turnover rates, limited time frame for academics, extra therapeutic duties required of teachers, and students' "limited skill set."

Across the 17 schools, apparent variability in academic quality and rigor existed as evidenced by differences in staff's stated commitment to academics, their level of licensure, and time committed to the academic curriculum. We were not provided with widely-accepted outcome measures, such as attendance, graduation rates, or standardized test scores, so those data could not be used as indicators of academic quality. All but one or two schools had evidence of at least half the facets of the suggested indicators of academic rigor and quality by the National High School Alliance (Muller & Chait, 2006, pp. 3–4).

Therapeutics

A primary aim of all schools was to provide a safe and sober environment in which the students could pursue their education. Schools also offered diverse types of therapeutic services to support students in their recovery, including such things as individual and group counseling sessions, chemical dependency education, family support and drug testing, among others. Most provided daily or near daily therapeutic time. Three therapeutic roles emerged that were common for most schools:

- to provide an environment and programs that demanded and supported student abstinence;
- to help students work through personal issues that threatened their abstinence and/or impeded their ability to do school work; and
- to provide students with the knowledge and tools to pursue recovery support later in life.

Therapeutic Philosophy—The schools' and/or staff members' philosophical perspective of chemical dependency often shaped the process by which the study schools approached these goals. Most schools embraced the "Minnesota model" of chemical dependency (Winters et al., 2000), which is rooted in the philosophy and teachings of the Twelve Step model founded by Alcoholics Anonymous (Alcoholics Anonymous, 2001), but incorporates a more holistic, biopsychosocial view, of recovery. For the schools, this meant adopting a view of SUDs as a chronic "disease", from which students were in various stages of "recovery". Eleven schools discussed either doing "step work" or referring to the Twelve Step program during group or individual therapy sessions, and all 17 study schools required students to attend outside Twelve Step or other support group meetings.

Impact of prior treatment—The approach to therapy by schools was often shaped by the *perceived* needs of the students. A few schools had a high percentage of students that had

not had previous treatment, so they tended to spend a comparatively high portion of their time and resources on SUD education. Other schools that had students who had previous treatment experience utilized group and individual therapy sessions to build upon what students learned in treatment or to provide a medium for students to work through their recovery issues with the support of a counselor and/or their peers.

Impact of co-occurring disorders—Studies have shown as many as 88% of adolescents who receive treatment for a SUD have a diagnosable co-occurring disorder (Dennis, 2004). Dennis found the most prevalent co-occurring disorders to be conduct disorder, ADHD, depression, anxiety, and traumatic stress. According to the student surveys, 49% of the students reported that they had received mental health specific treatment prior to enrolling at the school. In addition, eight schools claimed that more than half of their students were “dually diagnosed”, and another six schools conveyed that 25–50 percent of their students had diagnosed mental health issues. Despite these data, no school staff members or administrators identified student mental health issues as prominent in their therapeutic mission. Some schools refused to accept students with severe mental health issues, and those that did accept students with diagnosed co-occurring disorders discussed their issues as just part of the nature of the population of students pursuing recovery. They did not appear to consider specialized mental health support as within their purview.

Counselor Presence and Training—The schools’ therapeutic programs were also shaped by the constitution of their staff. The type of “counselor” and counseling services varied across the schools. Nine schools had at least one designated licensed counselor on-staff, although most were not licensed in chemical dependency or addictions. A lack of training in addictions was not generally seen as hindering the counselors’ ability to support students in their sobriety. Those schools with certified counselors and therapists on staff tended to provide more individual therapy sessions as part of their therapeutic program. A few schools had only one counselor who was also the administrator, and others outsourced their counseling with contracted therapists or alcohol and drug counselors. Four schools had an administrator that was a licensed counselor who played both the administrative and therapeutic rolls. Four schools did not have a licensed counselor on staff, but instead had the administrator and/or teachers serve as the “counselor.” Two of those schools also contracted with outside agencies to provide individual counseling when needed. Schools without licensed counselors on staff, as well as those for which the only counselor was also the administrator, were less able to provide individual therapy, especially the type of spontaneous therapy sessions demanded by students in recovery who struggled with daily “issues” and “crises.”

Staff with Recovery Experience—Regardless of the presence or lack thereof of a licensed counselor, staff at 11 of the schools cited the importance of having staff members with chemical dependency training and/or staff who were in recovery themselves as being extremely valuable to the therapeutic program at their school. This perspective is supported by the SAMHSA designation of best protocols as they claim, “Staff members who are themselves in recovery can offer unique hope, role modeling, and insight into dependency, addiction, and recovery” (Winters, 1999). According to anonymous survey data, about one-third of staff members identified themselves as being in recovery. These 22 staff members were present in 12 of the 17 study schools, which means five of the schools did not have a staff member who reported as being in recovery.[2]

[2]Due to the confidential nature of being in recovery, we cannot conclude, however, that the other five of the 17 schools did not employ or utilize a person in recovery. Volunteers also played a role in many schools that was not captured by our staff surveys. It can be assumed, though not verified, that some of those volunteers were people in recovery. Surveys were only distributed to paid staff, and interviews were only conducted with a handful of community volunteers across the participant schools.

Therapeutic Activities and Accountability

Group Counseling—All schools employed some type of group counseling during their school week. Groups allowed for "check-in" time, recovery planning, "venting", Twelve Step meetings, SUD education, and peer counseling. Groups met daily in 12 schools. Groups ran from 10–90 minutes and were run by the counselor(s), teacher(s), administrator, and/or an outside facilitator, depending on the make-up of the staff. Some schools held spontaneous group sessions when deemed necessary for either a particular class or the whole school community to deal with issues such as relapse or a student crisis.

Individual Counseling—All schools offered students the opportunity to discuss their concerns and issues with an adult. Counseling could consist of "as needed" sessions between a student and a dual-serving administrator/counselor, individual weekly sessions with an on-site licensed counselor, scheduled meetings with an outside contractor counselor, or anything in between. As mentioned earlier, nine of the 17 schools had a licensed counselor on staff to provide individual counseling to students. Counseling in the other eight schools was provided by either an administrator (all but one were licensed counselors or psychologists) or in the case of two schools, by outsourced counselors whose time was booked by the students.

Drug screening—Thirteen of the 17 schools utilized regular and random urine analysis drug testing (UAs) on their students as "part of the therapeutic process." The frequency ranged from two-to-three times per week to once monthly. The schools' goals were three-fold:

- to "*keep kids honest*"
- to *identify those students who were not complying* with the sobriety requirement
- social "norming" or social modeling. i.e., they provided students "an excuse not to use."

Relapse response—Staff members at all schools wanted students to leave the school with the tools necessary to pursue recovery *when*, rather than *if*, they relapse later in life. Most schools saw relapse as part of the recovery process and tended to give students multiple chances to become sober. Staff members stated it was "almost an expectation that they'll relapse," that "relapse is part of the disease," and "if early on, we expect them to relapse."

The schools' responses to relapses included less freedom and a more strict response if the student relapsed again; an increase in attendance at outside Twelve Step meetings; more individual counseling; more "relapse packet" work (i.e., psychoeducational/relapse prevention activities); journaling; and more frequent drug testing. Three schools described systems or "relapse plans" that outlined specific steps to take if a student relapsed. Four additional schools had students create their own, personalized plan after a relapse that addressed why they relapsed, what were the triggers, and how they would avoid it in the future. Two of these schools included other students in the creation of a new relapse plan, utilizing a peer accountability model.

Under certain conditions, schools were inclined to discharge students. These circumstances included multiple and/or extended relapses; dishonesty in reporting the details of a relapse; lack of willingness or commitment to following a school's program/rules; and encouraging or assisting other recovery students to use. In some instances, but not all, these actions led to immediate dismissal. In most cases, a student's prior recovery work and history was considered in discharge discussions.

Outside-of-school therapy requirements—Recognizing that students faced many issues outside of school and that there were many issues the schools did not feel equipped to handle, all schools placed outside-of-school support group and/or therapy requirements on their students. Virtually all schools required attendance at between one and three Twelve Step or other support group meetings per week, although it was unclear the extent to which schools tracked students' compliance. In addition to meetings, nine of the schools required students to secure a sponsor/mentor to assist in working through the Twelve Steps. Their goal was to help students develop support networks outside of school.

Family involvement—Whether or not a school solicited the engagement of parents in their students' recovery process appeared to depend in part on either the focus of the school or the community of students served. Six schools offered family groups that served as counseling or advice sessions, or as a way for parents to build peer support. Five of the schools put a lot of time and emphasis on developing a comprehensive program involving families. For three schools, parental involvement was actually seen as *detrimental* to students' recovery. As one administrator put it, "We don't seek out parental involvement, especially if the parent is using and a bad influence."

Summary and Discussion

The data collected for this study provide the first systematic description of recovery school programs and their students. Based on selection process, a nearly two-year process of data collection, and knowledge of the range of recovery schools, we believe the 17 schools studied are representative of the 35 recovery high schools in existence at this time. As a relatively new phenomenon, however, it is important to note that recovery schools are dynamic in nature and vary in student population size and stability, financial and governance arrangements, staffing, and organizational and physical arrangements.

The schools struggle with enrollment, funding, lack of primary treatment accessibility, educational program rigor and comprehensiveness, and institutional support. Indeed, most schools will accept students without prior treatment (22% of all students across the schools studied), so the range of understanding and motivation to change among students varies across schools. This along with the array of academic abilities and co-occurring disorders provide a complex student body that cannot be described simply as a group of adolescents "in recovery". Still, for those who have received treatment for substance abuse, recovery high school programs appear to successfully function as continuing care providers that reinforce and sustain the therapeutic benefits students gained from their treatment experiences. Additionally, the small size and therapeutic programming allow for a potentially broader continuum of services than currently exists in most of the schools. Recovery schools thus provide a useful design for continuing care that warrants additional study and policy support.

A particular model or design for recovery schools did not emerge, nor do the school programs cling together in such a way as to categorize them neatly within categories of type. Students come with a broad range of mental health issues and drug use patterns, criminal justice involvement, and educational backgrounds. While most students (78%) have had prior formal treatment for SUDs, nearly one-fourth of the students have not, and the complexity of student problems clearly limits and shapes the enrollment capacity, organization, and mission focus of the schools.

The question remains as to the exact definition of a "recovery school", as well as the appropriate scope of their therapeutic programs. Related to this question is the necessary balance between therapeutics and academics and how best to respond to the varied depth of

student needs for these services. From a therapeutic perspective, “Recovery” schools by definition appear to be best situated as continuing care programs. Figure 2 suggests the place of recovery schools on a care continuum.

The level of therapeutic service offerings in the schools in this study tended to depend on the needs of the students. Whereas schools with students straight out of treatment could simply reinforce students’ knowledge of chemical dependency and support their continued abstinence, other schools, such as those that accept large numbers of students from juvenile justice programs (which tend to be less voluntary and don’t necessarily provide treatment), had to provide more primary treatment services before being able to help move students to the “recovery” stage. All study participants indicated that having a school serve as a primary treatment source would be less than ideal, and due to time requirements, makes the ability to provide a rigorous academic program almost impossible. This suggests there is some value in building a base of students with prior treatment experience, especially immediately before enrolling in the school, and to have as much student choice as possible in the enrollment process. In order to “continue care”, schools need to (a) create adjunct programming to treat students without prior treatment or in need of further treatment and (b) provide a protective environment for students in recovery. If resources do not exist to do (a), schools should have partnerships with treatment centers that do.

Limitations of the Study

The limitations of this descriptive study are consistent with our intent to conduct pilot or feasibility research. We expect that our results will further elucidate models for recovery schools and begin to describe the students and programs. The limitations that prohibit drawing firm conclusions include the sample selected for the study, which we believe is representative but which was not randomly selected from all known recovery schools. The site visits were short (one day) and capture only a brief snapshot of school processes. Recovery schools are very dynamic environments in terms of resources, staffing, student enrollment, and organizational characteristics. By selecting schools with at least a two-year history, we stratified to assure some level of stability, but none-the-less our results must be seen to represent only a snapshot in time for these schools.

We do not intend to draw any more than general impressions about effectiveness at this time. As the data collected was descriptive in nature, this study did not address effectiveness of recovery schools, although such an assessment is needed and is a planned next step in our research. Furthermore, both time and cost limitations did not allow for a deep naturalistic inquiry. Such case studies will be needed to complement future evaluative research.

Potential to Impact System of Care

A key impetus for this study was to understand the work of recovery schools with the belief that there existed within them some potential to impact the system of care for adolescents with substance use problems and dependence. Not one interview or survey respondent suggested that the recovery school concept lacked value, and most staff noted they would choose to work in a recovery school instead of another setting. Student and staff satisfaction with their schools was consistently high. The environments provided by recovery schools offer the potential to support students along a broad continuum of needs that regular high schools have difficulty reaching with sufficient depth, and do so for a period of time that extends beyond that which most treatment facilities are designed to serve. Indeed, our findings suggest most recovery schools could serve even more students by:

- Creating more rigorous academic programs that address the education needs of learning disabled, gifted, struggling, and accelerated students;

- Establishing adjunct programs for students who need additional treatment services, either before they start in the recovery school or if they are having difficulties after admission; and
- Expanding their referral base and strengthening relationships with existing referral sources.

Those recommendations would expand the reach of recovery schools and help address the U.S. “treatment gap”, but should not be undertaken without assuring a supportive environment for students already in recovery. Though more research is needed for validation, the data suggest attempts to keep students in active recovery separated as much as possible from students actively using or unwilling to follow recovery school guidelines are well-founded, and efforts to broaden the scope of services should not consequently jeopardize the protective environments for students in recovery. Recovery high schools are not positioned to replace or substitute for primary substance abuse treatment on a large scale —their purpose remains continuing care. From a public health perspective, the nation still needs to expand the adolescent treatment system, while at the same time there appears to be a place for more recovery schools to provide safe, drug-free, peer support environments for the students with the greatest need.

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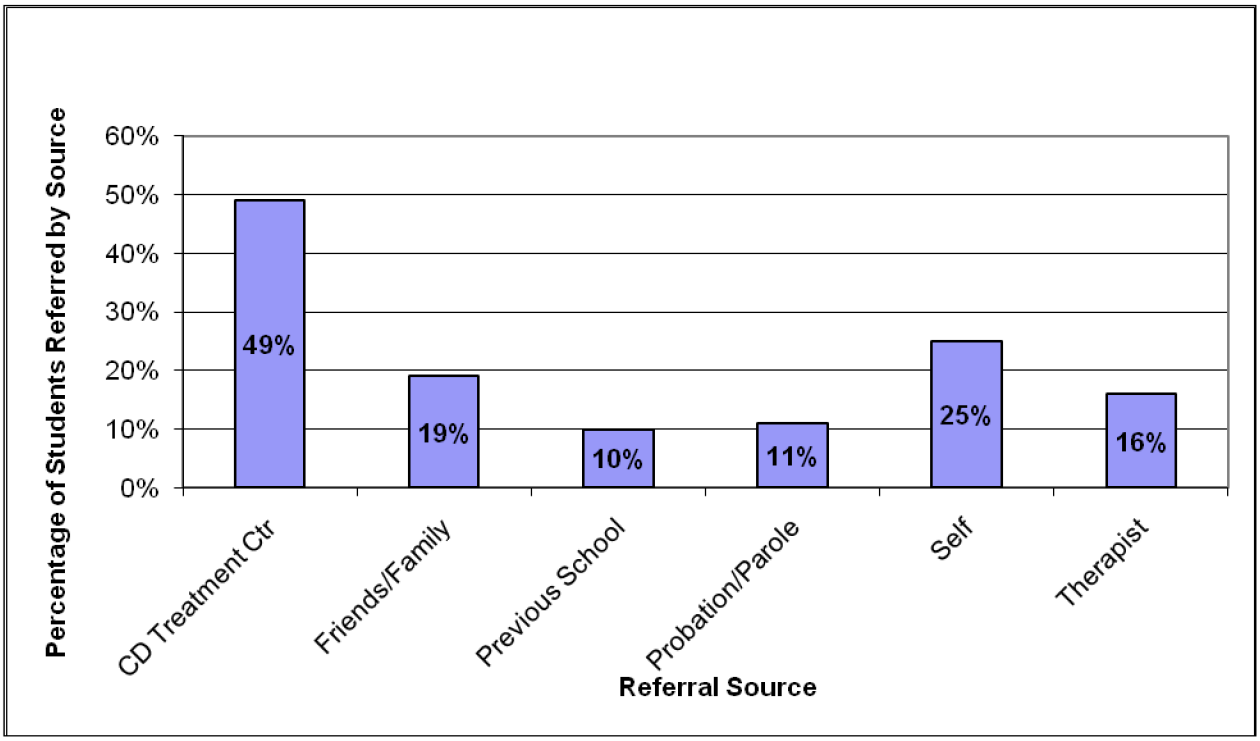

Figure 1. Reported Source of Referral to Recovery School (n=321)

Figure 1 summarizes the referrals sources as reported through student surveys. Students were allowed to choose more than one referral source.

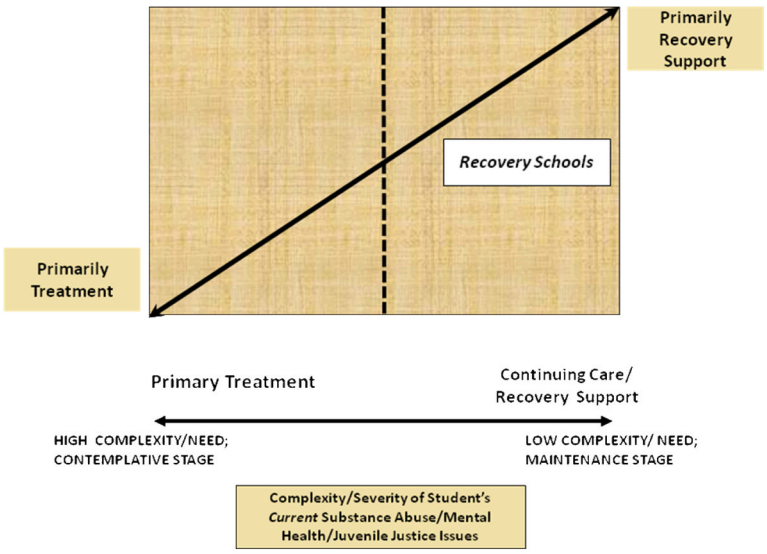

Figure 2. Continuum of Therapeutic/Treatment Services Provided

Note. This figure describes the position of recovery schools on the continuum of care. The continuum is represented by a line sloping up from left to right. The left side indicates programs that are primarily providing treatment, and the right side indicates programs primarily providing recovery support. Recovery schools tend to be positioned toward the right, as they provide primarily recovery support. Below the graph is a flat continuum line, displaying complexity/severity of a student's current substance abuse/mental health/juvenile justice issues. The left indicates high complexity/need, or the contemplative stage, and it is positioned directly beneath the left side of the graph (primarily treatment), while the right indicates low complexity/need, or the maintenance stage, and is located directly beneath the right side of the graph (primarily recovery support). This line suggests the students who would benefit most from programs along the continuum.