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Recovery Schools for Delaware Need and Feasibility Assessment

A report sponsored under contract with the Division of Prevention and Behavioral Health Services in support of the State of Delaware Behavioral Health Consortium

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EXECUTIVE SUMMARY

We investigated the potential for instituting a Recovery High School (RHS) in Delaware for youth who have been in treatment and need a means to resume education and maintain treatment. Recovery high schools are secondary schools for students in recovery from substance use disorder (SUD) or dependency. We also examined alternatives to a RHS and suggest some of the possibilities and pitfalls of these alternatives. The full report findings are summarized in four areas.

1. The first task was to look at the potential need for treatment among Delaware youth and young adults. DSCYF treatment numbers for youth have recently declined dramatically, but examination of school survey data showed only slight declines in youth substance use, with an estimate of 8% of HS students showing evidence of dependence on Marijuana, 3% on alcohol , and less than 1% on opioids, small percentages but indicating real numbers of youth potentially needing treatment. We looked at Medicaid data for DE youth and young adults and found more youth and young adults in treatment than would have been expected from the Division of Prevention and Behavioral Health Services (DPBHS) and the Division of Substance Abuse and Mental Health Services (DSAMH) numbers. The findings here are:
   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 youth is predominantly marijuana, with still a substantial number meeting criteria for treatment for alcohol;
   c) serious drug use and treatment use occurs in each County in close proportion to population;
   d) 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 seem less to be a focus of law enforcement, leading to fewer youth needing treatment through DPBHS being identified;
   e) changing patterns of drug use disorder by age in the Medicaid data strongly indicate that marijuana is the precursor to opioid abuse among young adults; however the DPBHS, DSAMH, and Medicaid data all suggest the recognition of the need to treat marijuana use has declined for both youth and young adults.

   The conclusion is that there is more need for treatment of youth in Delaware than has been recently recognized.
2. The second task was to examine RHSs nationally, and report on their promise, practices, and problems. A careful review of most of the existing RCCs show great enthusiasm among those running the schools but significant operational roadblocks:
   a) they are expensive to operate with high costs per student;
   b) even urban schools have transportation issues and all struggle with student ability and motivation to get to school;
   c) in many schools the education offers only core curriculum and use mostly online courses with limited teacher contact, few extracurricular activity options, and little interaction with other students;
   d) most schools have small enrollments, usually less than anticipated, and they struggle to maintain enthusiasm and enrollments after the first start up years;
   e) financial stability is a constant issue and RHSs scramble to maintain district and state funding and must raise additional funds.

   Research on RHSs has been limited, and the best evidence is from studies by Andrew Finch and colleagues sponsored by the National Institute on Drug Abuse. They only find evidence of a significant effect for marijuana reduction based on self-report (no drug testing) and a small effect for reduced absenteeism (though not controlling length of school attendance). Even the best RHSs have issues of relapse and levels of drug use more than found in public schools as a whole.

3. The third task was to document some of the resources (champions, federal state and local instrumental support) and barriers (cost, location, logistics, sustainability) to both establishing and maintaining programs in Delaware. We found many of the logistic issues would be as great or greater in Delaware as in existing RHSs, including:
    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 facility requirements are difficult in a small retrofitted facility;
    d) even many of the early proponents of a physical RHS in Delaware now recognize the logistical and political difficulties of a RHS.
4. The fourth task was to examine alternatives to be considered by the Behavioral Health Consortium (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) integrating a recovery support track in existing schools;
    b) expanding use of IEPs and 504 plans (while hiring more psychologists, teachers, and support staff to design and implement individual plans);
    c) hiring recovery coaches to work with students as they return to school;
    d) developing a collegiate recovery community for young adults coming back to school, perhaps at Delaware Technical Community College.

Alternatives for youth recovery and schooling exist, and it is seems that somethings need to be done and soon. A recovery high school could be a piece of the puzzle needed for a continuum of treatment services, but only a piece. 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. This could be accomplished with some combination of the options in Point 4 and described in this Report. One lesson that has become clear is that there is no one magic solution to the needs of recovering youth in Delaware, but there need to be better assessments and then a better array of alternative services for the needs of youth and young adults. The Opioid Epidemic has led to a focus on medicated assistant treatment for both acute and chronic treatment, but that is only a part of a solution for one drug and one that will become vestigial as drug users (always one step ahead or health responders) move to the new drug of choice. New funding from SAMHSA, the CDC, and CMMS are coming to Delaware; there may be other state funding; and even support from the pharmaceutical industry akin to the Tobacco Master Settlement. In keeping with the assessment education and prevention mandates of these programs and state efforts as a whole, we think Delaware should support more health professionals for school age youth and recommit to treating marijuana dependence as a serious issue and a gateway to more serious drug use that needs intervention programming.

Recovery Schools for Delaware Need and Feasibility Assessment

Introduction and Overview

In Delaware as in the nation, communities are confronting an increase in the misuse of opioid drugs, leading many to identify the current situation as a public health epidemic. The opioid class of drugs includes derived and synthesized prescription pain medications as well as illegal opiate drugs such as heroin. Opioids are very addictive and often the synthetic and compound versions are excessively potent leading to the grim statistics and tragic individual stories of repeated Naloxone (Narcan) use, drug overdose deaths, infants born with neonatal abstinence syndrome, criminal behavior, and countless hours of lost time that could otherwise be devoted to education, productive work, and family life. According to data from the National Survey on Drug Use and Health, the use of prescription pain medications without a prescription was the second most abused category of drugs in the United States, after marijuana, in the last two years (SAMHSA, 2018). And the significant albeit delayed federal response to better regulate prescribed opioid pain killers has led to a resurgence in heroin smuggling and the illegal importation of the powerful and evolving new class of fentanyl compounds from Asia. Most deadly has been the mixing and interaction of drugs and the lack of knowledge about exactly what is being ingested.

This public health crisis impacts people across all age groups and all communities, and comes with high social and public costs; the US Department of Health and Social Services reports over $78 billion in costs related to opioid dependency and misuse in a single year (National Institute on Drug Abuse, 2019). Deaths due to drug overdoses steadily increased across the United States between 2014 and 2017, and, although there has been a small decrease in 2018-2019, six out of every ten overdoses have been connected to opioid use. Yet while the opioid crisis has been the face of a new drug abuse epidemic, it is also the case that four out of ten of the overdose deaths are not attributed to opioids. And it is true that drug related deaths have been concentrated among adults, not youth under 18.

Delaware Context and This Report

Delaware has been hit hard by the opioid epidemic as well. In 2017, Delaware had the 6th highest drug overdose death rate of the 50 states (CDC, 2019). Delaware's drug overdose rate, across all categories of drugs, has increased in the past few years. In 2017, 61% of overdose deaths involved fentanyl, 39% involved heroin, and 29% involved other opioids, very often in combination with other opioids or other types of substance (Delaware Division of Forensic Science, 2018). To help deal with the opioid crisis in Delaware, the State was recently awarded a multiyear multimillion dollar grant under the federal Overdose Data to Action initiative. The aim is to support a comprehensive and interdisciplinary approach to the opioid problem that focuses on surveillance

and prevention. One stated focus of the grant is to partner with community groups to provide a grassroots response to the crisis using data to direct targeted intervention and prevention efforts. The enhanced availability of data, along with robust partnerships within the community, will assist Delaware to tailor activities and programs to address specific trends that may be occurring.

It is in this context that this Report seeks to offer possibilities for understanding the needs for treatment of youth and young adults and investigate the possibilities and pitfalls of some models to assist youth and their families. This Report began with a more specific charge from the Behavioral Health Consortium and the Department of Services for Children, Youth and Their Families' Division of Prevention and Behavioral Health Services (DSCYF/DPBHS) to investigate the potential for instituting a Recovery High School (RHS) in Delaware for youth who have been in treatment and need a means to resume education and maintain treatment. Recovery high schools are secondary schools for students in recovery from substance use disorder (SUD) or dependency. There are less than 40 of these schools nationally operating with very different clientele and resources, as described in section 2 of this Report, but they have shared aims: 1) to educate students who are in recovery from SUD and related mental health issues; 2) to support students' recovery as they further education; and 3) to be able (independently or with other schools) to award school credits and diploma. Schools are usually small (5-50 students) with high staff to student ratios providing teachers, counselors, and health professionals to support student progress. Where possible schools provide support to families in supporting their teens in recovery and school.

The impetus for a Recovery High School in Delaware came from community advocate agencies, individual parents and a few young adults. Community advocates and champions were searching for more resources and more options for services for youth with substance abuse problems. As in many public health crises where there is a new "instigation" (e.g., crack in the 1980s, ecstasy in the 1990s, vaping in the past two years), the public health response is delayed and reactive rather than proactive. The visible problem was particularly poignant for the cases of teens first introduced to opiates through the health industry push toward relieving pain through new medications (fentanyl) or more often new formulations of old medications (e.g., morphine and codeine in hydromorphone and hydrocodone compounds with new delivery in time release, patch, and more potent formats). Calls for more treatment services, particularly residential have increased from individuals, community groups, and some legislators. And one mechanism that has had visibility over the last decade is the Recovery High School. There were at least 3 serious attempts to start a RHS in Delaware in the past 5 years, but the impetus seemed more that "we need to do something" (a sentiment coming from more than one community advocate) rather than knowing whether this would be an effective approach in Delaware. The state requested an overview of the need, feasibility, and impact of such a service (Recovery High School or High Schools) in Delaware, leading to this Report. There four aims of this report are:

1) Get the best count and description possible of the need for a Recovery High School in Delaware by looking at data for numbers of high school age students (with a "confidence interval" of middle school and young adults) who a) used alcohol and other drugs regularly and 2) who had been in treatment for substance abuse;

2) Look at the best models for Recovery High Schools that have been in operation nationally, talk to researchers and policymakers who have studied and supported these efforts, and report on the utility of the Recovery High School movement nationally;

3) Document some of the resources (champions, federal state and local instrumental support) and barriers (cost, location, logistics, sustainability) to both establishing and maintaining programs; and

4) Examine alternatives that should be considered by the Behavioral Health Consortium (BHC), community champions, and other policy makers in Delaware to provide needed services for the dual goals of recovery and education.

In approaching the subject and gathering information over the last 8 months, it is apparent that key stakeholders' opinions and attitudes have been changing, with additional data becoming available, and we seek to reflect these developments in the report.

1) **Consideration of Need for treatment services of youth in Delaware, as evidenced by number of substance abuse affected youth and seriousness of their need for treatment and education services.**

Existing data on need come from a variety of survey sources, reports of those in treatment in public programs at DSCYF/DPBHS (youth under 18 and potentially on Medicaid or without insurance coverage) and DHSS/DSAMH (young adults), data from other existing treatment programs, data from state Medicaid claims for those youth and young adults receiving treatment related services, and personal statements from community service providers and advocates. We begin by presenting data from the Delaware School Survey of 8th and 11th graders from 2018 and from the Delaware Youth Risk Behavior Survey from 2017 (data from Spring 2019 are not yet available). The surveys are conducted from January into June each year as an anonymous classroom administration using a form that can be completed in one class period. They are administered by University of Delaware personnel, rather than by teachers, to help increase students' perceptions that the results are not seen by school personnel.

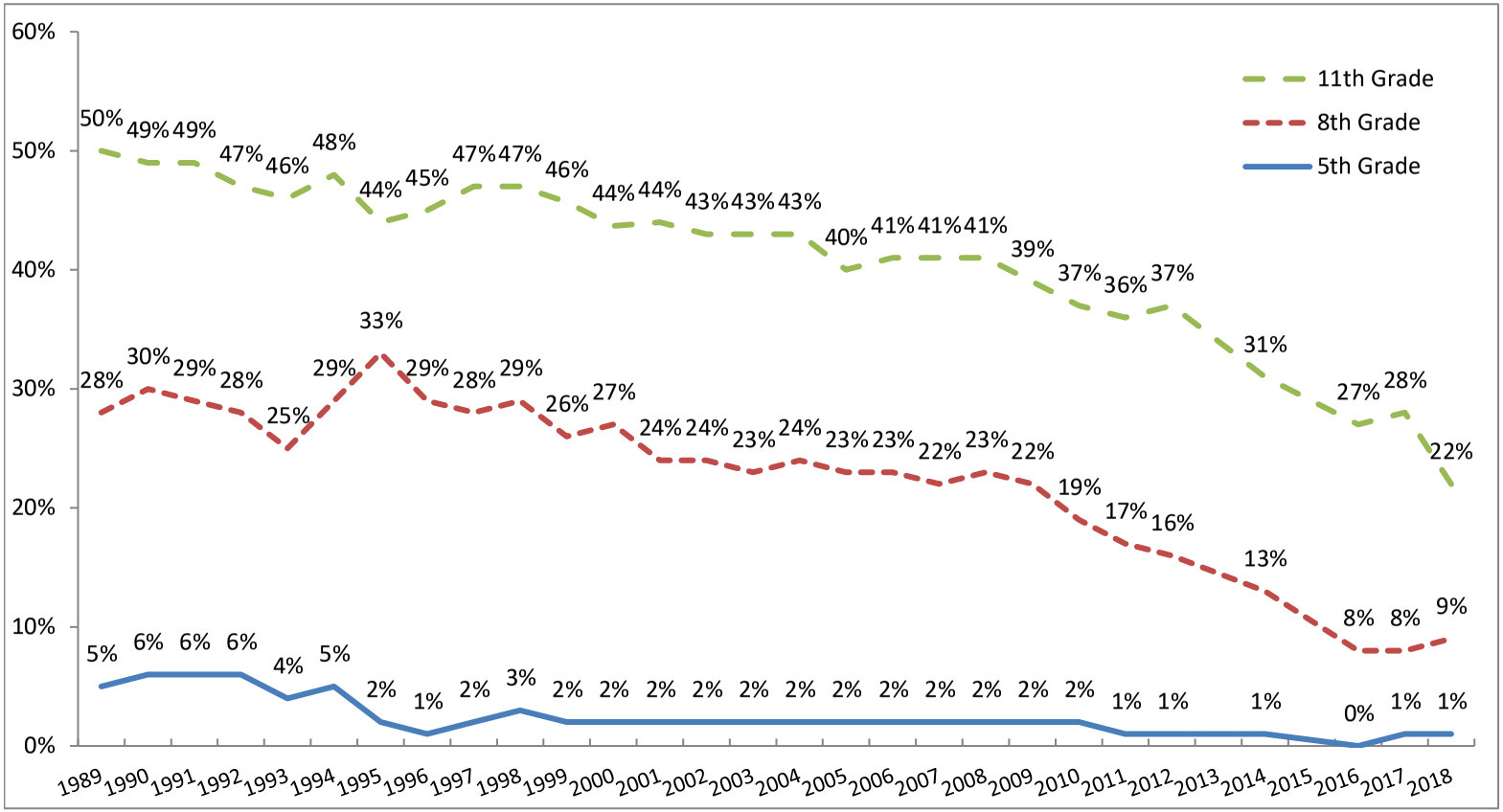
In 2018, Delaware School Surveys (DSS) were completed in 18 of the 19 school districts (the Caesar Rodney School Board declined to participate) as well as 24 Charter Schools. The number of completed interviews, excluding any students who reported using a fictitious drug (included as a question) or who otherwise obviously falsified their answers, were 4678 8th graders and 3909 11th graders. These represent census participation of all students in these schools in school on the day of administration minus those classrooms randomly selected to be in the 2018 Youth Tobacco survey or for 2017 those classrooms in the 2017 Youth Risk Behavior Survey. So the samples are large and statistically representative of the population in school. Each of the DSS samples since 1999 allows for statewide and countywide estimates that have much greater reliability and smaller confidence intervals than were available in previous years or in other studies.

The most recent data available are for 2018, and they show relatively small percentages of 11th graders who report using alcohol or other drugs. (The most disconcerting finding is the rapid increase in e-cigarette use and vaping.) Long term trends show a decline in alcohol (Figure 1) and marijuana (Figure 2) use and the trend data for other drugs over the last twenty years have generally declined or are stable (Figure 3). Even for the patterns of drug use most likely associated with need for treatment, there is little evidence of heavy drinking, or opioid painkiller use, but higher levels of heavy marijuana use. A little more than 1% of 2018 11th graders were "heavy" drinkers (more than 20 drinks a month) or past month prescription opioid users, but almost 11% were heavy marijuana users (6 or more times in the past month). This is ten times more for marijuana use than for alcohol or prescription pain killers. But even the marijuana use seemed understandable in light of society's changing attitude toward marijuana as evidenced by the legalization of medical marijuana and seemingly inexorable move to decriminalize and eventually legalize recreational marijuana use for adults.

These questions and the responses shown on the following three pages give some idea of the potential need for treatment that exists for Delaware high school students. Yet these relatively low overall state substance numbers for high school students belie the fact that serious substance abuse may be more geographically concentrated, and that small but significant numbers may be truly in need of treatment and other services that are not readily available in the state. The Center for Drug and Health Studies at UD have recently been mapping substance use including that reported in the Delaware School Surveys. Figure 4 shows a map of the use of prescription pain killers by Delaware students in the past year aggregating data from the 2017 and 2018 surveys. The color coding in the electronic version of the report makes it easy to see that the location of students using prescription pain killers is far from evenly distributed in the state and there are areas of concentrated use. Of note these areas of higher use exist in each Delaware county, and are not a New Castle County only issue. More data on school survey results for the most recent year, 2018, are available in the full report that can be accessed from this link.

https://www.cdhs.udel.edu/content-sub-site/Documents/2018%20DSS%20State%20Report.pdf

Figure 1: TRENDS IN DELAWARE STUDENTS' ALCOHOL USE BY GRADE SELF-REPORTED REGULAR USE*, 1989 - 2018



Notes:

Regular use is defined as reports of one drink per month or more often; see footnote page.

Displayed percentiles are rounded to the nearest whole number.

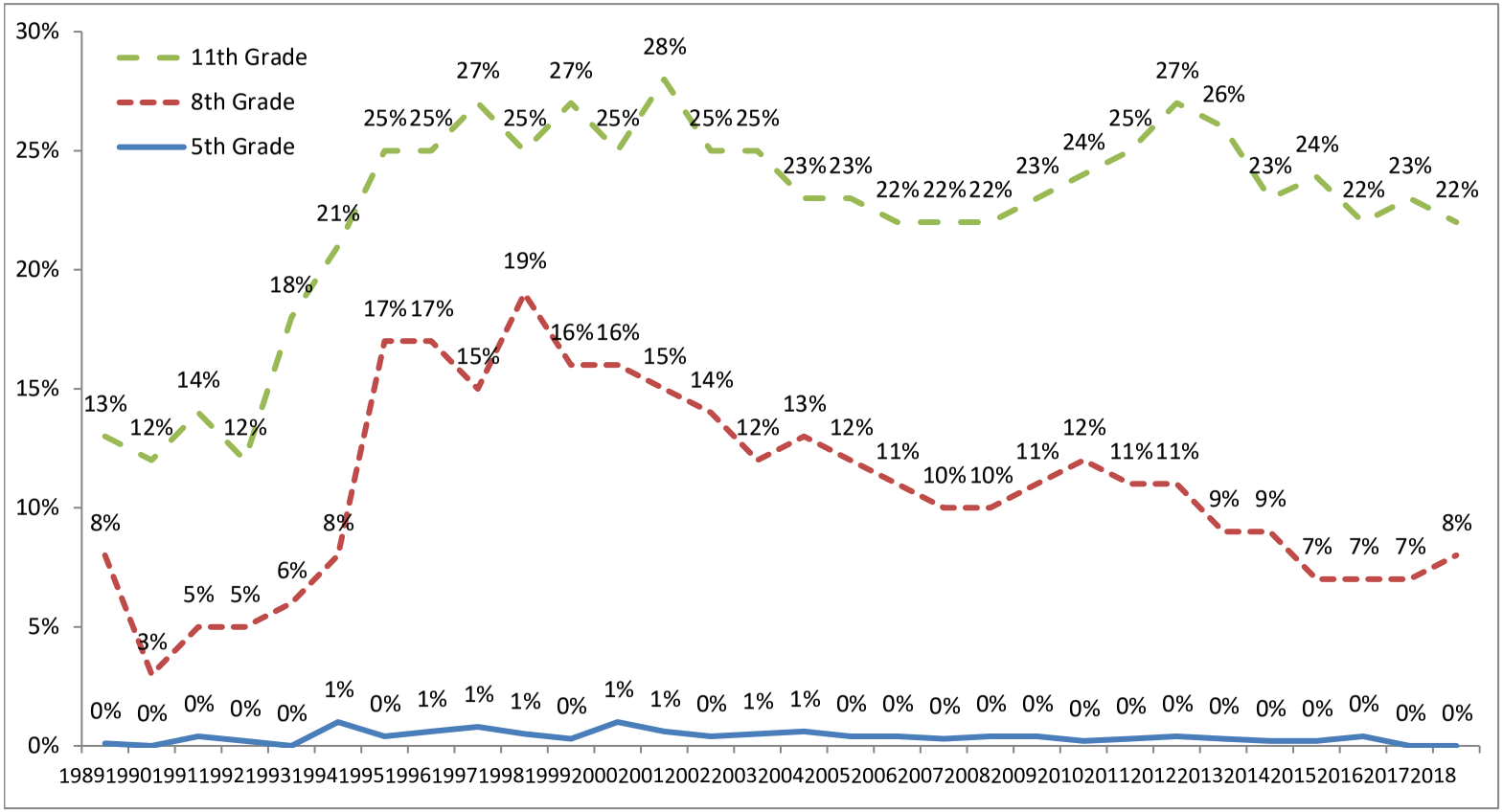
These statistics contribute to the National Outcome Measures (NOMs)

Sources:

Data Base/DiagnosticsPlus (1989-1993); Department of Public Instruction (1994)

Delaware School Survey, Center for Drug and Health Studies, University of Delaware (1995-2018).

Figure 2: TRENDS IN DELAWARE STUDENTS' MARIJUANA USE BY GRADE SELF-REPORTED REGULAR USE*, 1989 - 2018



Notes:

Regular use is defined as reports of smoking marijuana once a month or more often; see footnote page.

Displayed percentiles are rounded to the nearest whole number.

These statistics contribute to the National Outcome Measures (NOMs)

Sources:

Data Base/DiagnosticsPlus (1989-1993); Department of Public Instruction (1994)

Delaware School Survey, Center for Drug and Health Studies, University of Delaware (1995-2018).

Figure 3: TRENDS IN MONTHLY USE OF OTHER ILLEGAL DRUGS AMONG DELAWARE ELEVENTH GRADERS 1989-2018 (Percentages)

DRUG	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Inhalants	2	1	4	2	3	3	2	3	3	3	2	2	2	1	1	-	1	-	-	-	-	-	-	-	-	-	-
Hallucinogens	2	3	4	3	3	3	3	2	2	2	1	-	-	1	1	1	-	-	-	1	-	-	-	-	1	-	-
Stimulants	3	3	4	2	2	4	3	2	3	2	1	2	1	1	1	-	-	1	-	-	-	-	-	-	1	-	-
Cocaine	1	-	1	1	2	2	2	1	1	1	-	1	-	1	1	1	1	1	-	-	-	-	-	-	-	-	-
Heroin[a]	-	-	na	1	1	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-
Designer Drugs/ Ecstasy[ab]	na	na	na	-	1	1	1	1	3	2	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Ritalin[a]	na	na	na	na	na	na	na	na	na	2	2	3	2	2	2	2	2	2	2	2	1	1	1	-	1	-	1
Painkillers[a]	na	na	na	na	na	na	na	na	na	na	4	4	4	4	4	4	4	4	4	3	3	3	1	2	1	1	1
Prescription Drugs (Past Year)[a]	na	na	na	na	na	na	na	na	na	na	na	na	na	18	22	20	20	21	20	20	19	17	13	14	12	12	13
Any Illegal Drugs (excluding marijuana)[a]	na	na	na	na	na	na	na	7	8	8	6	9	8	7	7	6	7	7	6	6	6	5	6	4	3	3	4

Notes:

(-) indicates less than one-half of one percent.

[a](na) indicates question was not asked that year.

[b] Through 1999, the question asked about "designer drugs (XTC, Special K & Roche)". From 2000 on, the question asked explicitly about ecstasy.

[c]Inhalant question altered in 2005 and subsequently

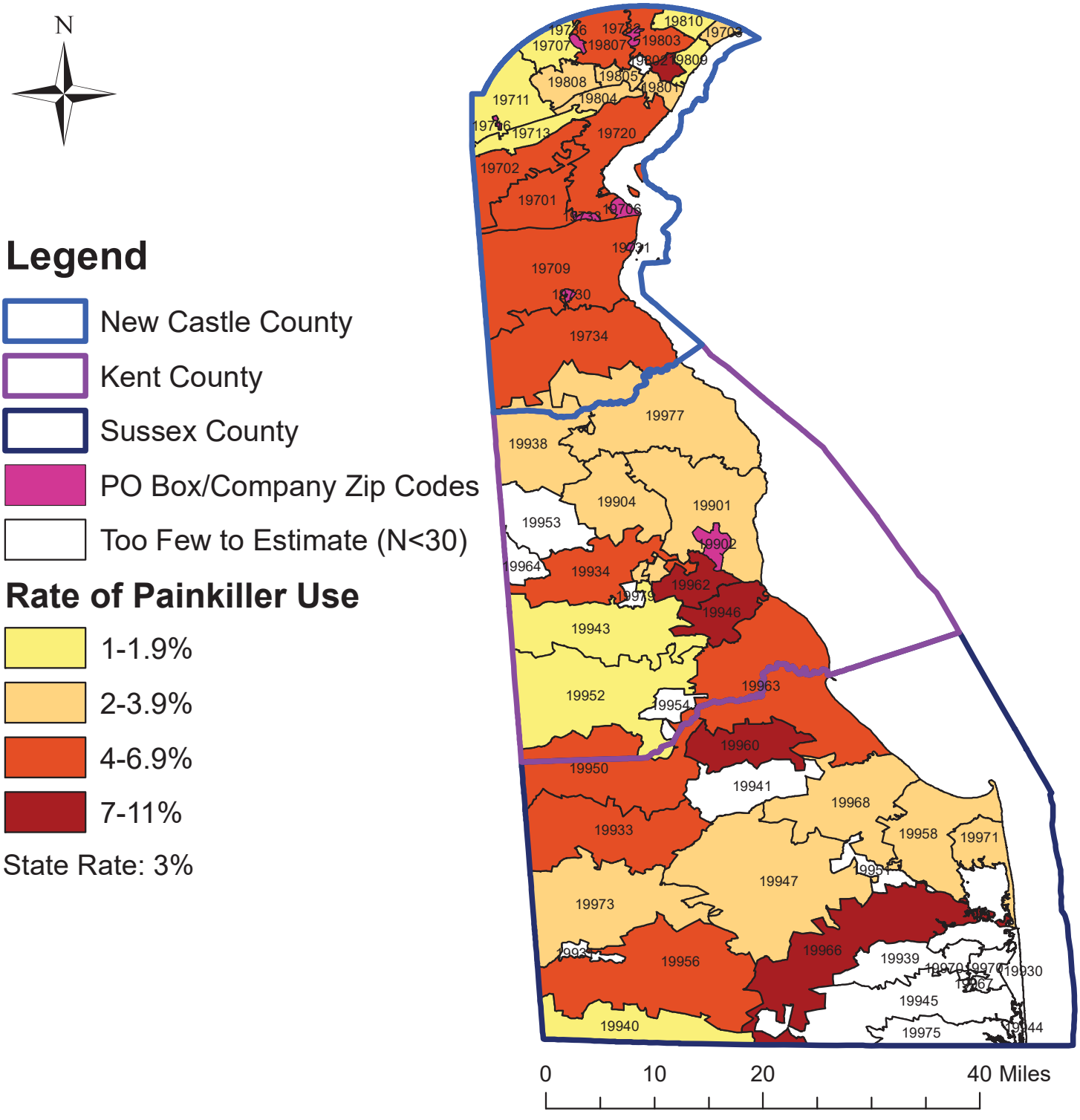
Displayed percentiles are rounded to the nearest whole number.

Sources:

Data Base/DiagnosticsPlus (1989-1993); Department of Public Instruction (1994)

Delaware School Survey, Center for Drug and Health Studies, University of Delaware (1995-2018).

Figure 4. Reported Past Year Prescription Painkiller Use Without a Prescription Among Delaware 11th Grade Public School Student: 2017-2018



Data Source:
2017-2018 Delaware School Survey, Center for Drug and Health Studies, University of Delaware
www.cdhs.udel.edu/seow

Better direct survey indicators of substance use commensurate with treatment need come from a series of 5 questions asked related to the diagnosis of dependence on a substance that were asked in 2016 and 2017. The questions asked if the student wanted to cut down, was unable to cut down, needed larger amounts, used daily for two weeks or more, and had withdrawal symptoms. These are the basic questions for Diagnostic and Statistical Manual (DSM) diagnoses of dependence and the core questions used for estimating dependence in the National Survey of Drug Use and Health. The 2016 data found about 120 students met dependence criteria for alcohol, about 289, for marijuana, and about 35 for prescription pain killers. For 2017 the numbers were respectively 130, 278, and 33. Because some classrooms received the CDC YTS and YRBS surveys, we adjust these estimates up to account for all classrooms in the 11th grade in 2016 and 2017 to the following 11th grade population estimates:

Table 1. Population estimate Delaware 11th graders	**2016**		**2017**	
Indication of dependence on alcohol	150	3%	162	4%
Indication of dependence on marijuana	370	8%	355	8%
Indication of dependence on prescription pain killers	46	1%	41	1%

Unfortunately, the survey advisory committee eliminated these questions from the 2018 survey, but the 2018 survey did add a question about receiving emergency treatment in the past year for use of alcohol, marijuana, and prescription pain killers respectively. For 2018, 49 students reported receiving emergency medical treatment for alcohol use, 20 students for marijuana use, and 19 students for prescription painkiller use. These estimates suggest there are a small but meaningful number of students in the public schools who can be considered in need of treatment. Moreover, these absolute counts of those with an indicated dependence criteria or receiving emergency treatment come only from 11th graders, so the numbers for all high school students (9-12 grades) will be at least twice as much.

These data come from in-school anonymous survey responses by youth in Delaware public schools. They have a major limitation in that they only represent students who are still in school and who were in school the day the survey was administered. Substance abusers by 11th grade are likely to have dropped out and, even if still in school, are more likely to be absent from school. Moreover, the estimates come from public school surveys only; the parochial and independent schools are not included. (Interestingly, the independent schools participated in the surveys once over 30 years ago, and, when they showed higher levels of substance abuse, the independent schools declined to participate again. Twenty years ago, the parochial schools participated for one year, found their estimates higher than the public school estimates and declined to participate again.) So these estimates are the low end of substance abuse suggesting potential need for treatment (in the case of the use estimates) and a baseline for actual numbers of youth who meet criteria of abuse and dependence and who have received emergency treatment for substance abuse.

School survey data, though not a comprehensive source of information on youth substance use in Delaware, are helpful when examined in the contest of other indicators. We look now at treatment data.

One of the reasons that state officials have thought there was not an increasing need for treatment and perhaps a declining need for services for youth is that there has been a decline in the numbers of unduplicated youth in treatment in the Department of Services for Children, Youth and Their Families (DSCYF). Data provided by the Department and the Division of Prevention and Behavioral Health Services (DPBHS) and its FACTS system for the years 2016-2018 show a marked decline in the number of youth under age 18 receiving services, with almost a 50% decline from 2016 to 2018. These data led to the creation of the Substance Abuse Referral Action Committee (SARAC), the actions and conclusions of which are discussed later in this report.

Table 2. DSCYF/DPBHS Substance Abuse Client Population

	FY16	FY17	FY18
Unduplicated Clients	**232**	**165**	**122**
Gender			
Female	70	46	33
Male	162	119	89
Race			
American Indian			2
Asian	2	3	2
Black/African American	117	68	52
White	113	94	66
Ethnicity			
Hispanic or Latino	34	29	32
Not Hispanic or Latino	198	136	90

There are several possible explanations for this decline. Referrals through courts and schools have declined. Also, with the state fully implementing the provisions of the Affordable Care Act in Delaware, services are being directly provided and charged through Medicaid without being reflected in the DSCYF service records. It may be the case that some services previously provided through DSCYF are now being billed through Medicaid.

For those over 18 years of age, records for those receiving treatment services through the Department of Health and Social Services' Division of Substance Abuse and Mental Health (DSAMH) are maintained by DSAMH. The most recent data available, posted in February 2018, are for 2016, and the data are for admissions rather than unduplicated individuals (Table 3). The ability to record accurate data has been challenging for DSAMH as can be seen in the information on primary drug of abuse. Specific drugs even including heroin, other opiates and synthetics declined in 2016 while the "other/unknown" category grew dramatically in 2016. In fact the "other/unknown" category for primary drug which was only 164 in 2003 had ballooned to 4526 in 2016. DSAMH is revamping its system to improve reporting, and, for purposes here, the most important numbers are the admissions for young adults 18-20 and 21-24, which are thought to be accurate. Admissions (again not unique individuals) declined from 664 in 2015 to 435 in 2016 for those 18-20; while admission for those 21-24 declined from 1,586 in 2015 to 1,424 in 2016. Looking over the expanse of data

Table 3: Delaware Health and Social Services - Division of Substance Abuse and Mental Health
Division funded adult admissions by fiscal year and client demographics - State Fiscal Years 2003 - 2016

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Primary Drug at Admission														
Alcohol	2,706	2,685	2,336	2,142	2,267	2,107	2,127	1,924	1,729	1,579	1,513	1,105	1,093	729
Heroin	2,124	2,390	2,234	2,113	2,080	2,120	1,965	1,529	1,263	1,845	2,750	3,182	3,723	3,016
Cocaine	510	527	533	481	643	548	429	301	247	262	180	146	107	102
Crack Cocaine	1,000	1,017	943	908	831	680	457	284	183	177	126	125	143	71
Marijuana/Hashish	1,631	1,666	1,801	1,875	1,933	1,613	1,806	1,539	1,348	1,161	1,055	705	873	470
Amphetamine	20	21	18	43	27	28	12	13	10	20	12	22	30	8
Other Opiates & Synthetics	168	252	286	433	736	927	1,400	1,359	1,643	1,793	1,261	766	643	476
Other/Missing/Unknown/None	164	324	329	463	319	396	394	426	439	659	693	1,179	3,265	4,526
Age														
16 - 17	6	0	0	13	0	0	0	178	184					
18 - 20	680	722	952	858	1,075	673	985	1,021	1,086	720	602	561	664	435
21 - 24	1,266	1,375	1,342	1,340	1,523	1,329	1,405	1,172	1,180	1,282	1,332	1,302	1,586	1,424
25 - 34	2,431	2,663	2,528	2,560	2,564	2,693	2,756	2,269	2,076	2,749	2,934	2,718	4,097	3,940
35 - 44	2,632	2,685	2,370	2,227	2,215	2,056	1,849	1,467	1,219	1,328	1,400	1,411	1,871	1,958
45 - 54	1,064	1,127	1,034	1,196	1,003	1,362	1,229	995	859	1,042	937	874	1,200	1,138
55 - 64	196	245	193	231	191	253	305	234	213	299	319	296	384	426
65+	35	45	38	33	31	49	43	32	39	54	65	62	56	69
Missing/Unknown	13	20	23	0	234	4	18	7	6	22	1	6	19	8
Gender														
Male	6,425	6,822	6,584	6,237	6,580	6,129	6,227	5,235	4,790	5,161	5,131	4,875	6,933	6,545
Female	1,896	2,055	1,892	2,214	2,255	2,290	2,363	2,139	2,069	2,322	2,450	2,317	2,927	2,840
Missing/Unknown	2	5	4	7	1			1	3	13	9	38	17	13
Race														
White, not of Hispanic Origin	5,071	5,453	5,314	5,420	5,987	5,743	5,967	5,178	4,940	5,453	5,785	5,621	7,016	6,397
Black, not of Hispanic Origin	3,028	3,057	2,736	2,628	2,516	2,390	2,328	1,978	1,677	1,671	1,473	1,286	2,404	2,457
Asian or Pacific Islander	86	29	24	25	22	15	15	19	31	30	39	21	33	33
Native American	46	66	174	204	94	38	62	33	30	74	69	57	103	157
American Indian/Alaskan Nat.	-	0	52	50	48	53	70	38	40	85	65	79	67	63
Other/Multi-racial, unspecified	43	242	58	88	134	141	110	102	89	73	85	52	79	92
Missing/Unknown	49	35	122	43	35	39	38	27	55	110	74	114	175	199
Hispanic														
Of Hispanic Descent	392	448	437	384	476	417	464	343	294	354	367	321	525	447
Not of Hispanic Descent	7,894	8,393	8,005	8,035	8,329	7,982	8,093	6,997	6,464	6,986	7,110	6,708	8,860	8,299
Missing/Unknown	37	41	38	39	31	20	33	35	104	156	113	201	492	652
Total	8,323	8,882	8,480	8,458	8,836	8,419	8,590	7,375	6,862	7,496	7,590	7,230	9,877	9,398

Footnotes:
1) The total for amphetamine includes methamphetamine.

from 2003 to 2016, admissions for those 18-20 have declined somewhat while admissions for young adults 21-24 have remained relatively stable.

The data from both the DSCYF system for youth and the DSAMH system for young adults have led the state to not see a great increase in need for services, since the number of youth and young adults in the state systems have actually been declining in recent years despite the opioid epidemic increase in emergency resuscitations and deaths. This conclusion that the need for treatment is not large or growing has been challenged by community activists who maintain there are more youth in need of treatment in the state's own data. For example, using unpublished data from the DSAMH reporting system for 2017 that were included in the 2018 Delaware Drug Monitoring Initiative Report, *atTAcK addiction* include the following excerpt in their Newsletter to indicate the number of youth in treatment in Delaware.

> The data provided by the Division of Substance Abuse and Mental Health (DSAMH) were collected between January 1, 2017-December 31, 2017, reflecting a total of 13,638 admissions of substance use disorder clients throughout the State of Delaware. The data reflect a majority of individuals identifying heroin (reported 5,765 times) as the primary drug at admission. It is important to note that 3,213 individuals did not have a primary drug at admission reported, indicating a need for more comprehensive data collection to better Identify and respond to emergent drug trends. From the data, Individuals 25 to 29 years of age were the group whom represented the most in treatment admissions during this period. In addition, there were 346 admissions for individuals between the ages of 15 to 19, which highlights the need to begin prevention efforts perhaps in adolescence to curb this early abuse.

When we investigated the origin of these numbers, which are much larger than those reported by DSCYF, we were told by DSAMH that the number is likely a misreporting of DSAMH data being fitted to DBI age categories. Division Director Romero reported; "That report is only for data that reflects DSAMH's clients of 18+... but DMI report has age groupings that actually go 15-19…. and isn't accurate to reflect a high school age." It appears those 346 admissions are for those 18-20, and represent a decrease from the numbers noted above for 2016. The fact that the number reported is incorrect does not negate the DDMI report conclusion that prevention in adolescence is important to forestall and limit progression to more serious substance abuse in adulthood.

The data examined so far are from self-reported surveys and from state treatment databases. A third and perhaps the most relevant source for determining need for the ongoing substance abuse and educational services for youth and young adults comes from the claims and encounter data of those who received substance use disorder services under the state Medicaid system. State Medicaid data overseen by the Delaware Division of Medicaid and Medical Assistance (DMMA) is the most comprehensive, well maintained and monitored, and addressable database on publicly funded client services and it also provides information that can be used for research and evaluation. The University of Delaware's Center for Community Research and Service (CCRS) has partnered with the State to provide evaluation assistance to DMMA and to (with DMMA permission) provide access to de-identified data for DMMA approved evaluation and research projects.

Delaware State Medicaid data are shown below in Tables 4-11 for unduplicated youth and young adults receiving a diagnosis of substance abuse disorder (SUD) or treatment services, as evidenced by the International Statistical Classification of Diseases and Related Health Problems version 10 (ICD-10) reimbursement codes for alcohol and other drug use disorder services. The number of youth and young adults in Delaware who may be candidates for treatment or related services should include both those with an indicated need because they have been getting treatment service and those with a potential need because they have a diagnosis of substance use disorder. Since these are unduplicated cases, both diagnosis and treatment cases are important to estimate the numbers who may benefit from new services. In fact it appears that most (almost 80%) of the substance use disorder cases in the Medicaid data are getting treatment services. These data are important, particularly the data from Medicaid about numbers of youth and young adults receiving services for substance use disorder. Getting permission to access the DMMA controlled Medicaid data required a stated purpose and proposal for use and the protection of client identity, but with the help of the Center for Community Research and Service and the DMMA staff, we obtained access to the Medicaid data for Delaware youth and young adults for the past two state fiscal years, Fiscal Year 17 and Fiscal Year 18.

The examination of Medicaid Data for youth and young adults has a two-fold purpose:

1) Obtain de-identified aggregate counts of both youth (15-17) and young adults (18-24) and by age, race, county, and gender who received services under established Medicaid codes for substance abuse diagnosis, treatment, and services during each of FY2017 and FY2018 (the ICD-10 codes for both substance involvement and relevant procedures are included in the Appendix A1 to the Report).

2) Work with our identified contacts at each of DSAMH (Kris Fraser) and DSCYF (Laura Wood) to provide listings of Master Client Index (MCI) numbers for each of 2017 and 2018 for clients 15-24 who received substance abuse treatment services from each of DSAMH and DSCYF. Discussions with DSAMH and DSCYF suggest there has been a move to more Medicaid billing for services provided through DSAMH and DSCYF, so there may be duplication in any estimates from the aggregate of these sources leading to inflated state need estimates. Plans called for listings with MCI numbers to be shared directly by DSAMH and DSCYF to CCRS, CCRS would look for overlap in the state treatment and Medicaid databases and produce estimates, and this project would only have access to the de-identified results. As seen below, only data from DSCYF were able to be matched with Medicaid at this time. Nevertheless, we think the limited cross database results reported below are suggestive of the need for more cross data base reporting and checking in the future, a process that will be useful to DMMA, DSAMH, and DPBHS as well since it will enable the state to see a combined and unduplicated count both of adolescents and young adults receiving behavioral health services across state agencies with the ability to look at both the counts of individuals and the number of services received.

The definition for subjects to be included in the data calls for those in the Medicaid/CHIP full benefit aid category for at least one month during the fiscal year and between the ages of 15-24 with a diagnosis of substance abuse (SA, excluding nicotine abuse, codes as noted in Appendix A1).

Data were examined for each of Fiscal Year 17 and Fiscal Year 18. The Table 4 below breaks down the results for non-duplicated individuals in each year, by age, from 15 to 24.

Table 4. Youth and Young Adult Delaware Medicaid Clients Treated for SUD by age, FY 2017 and FY2018

Age	FY 2017		FY 2018	
	#	%	#	%
15	122	4%	104	4%
16	175	6%	137	5%
17	229	8%	195	7%
18	261	9%	222	8%
19	221	7%	215	8%
20	262	9%	292	11%
21	309	10%	309	11%
22	389	13%	286	11%
23	447	15%	399	15%
24	590	20%	549	20%
Total	3005	100%	2708	100%

Notable here are the absolute number of clients receiving services in each age group from 15 to 24. The pattern for each of FY2017 and FY2018 are quite consistent with increases of about 35-50 clients per year up through age 18. There is a drop at age 19 (probably due to Medicaid qualification for those over 18), but then again a steady climb of 50-100 clients per year from age 19 to age 24. Besides the relatively large number in each age category receiving SUD services, the most important finding is that the number of youth being served for substance abuse is more than three times greater than the number of cases in the DSCYF FACTS database for each of these years. There are 526 cases 15-17 in the Medicaid data for FY2017 and 165 in the DSCYF/DPBHS FACTS system and 436 clients in Medicaid 14-17 while 122 cases in DSCYF/DPBHS for FY2018. It appears that many youth are receiving diagnoses and services for SUD not directly through or noted in the DSCYF/DPBHS databases. With more years of both DPBHS and Medicaid data, we could ascertain if this has been a recent trend, but it is the case that each data base seems to be showing a decline of youth in treatment. For those 18-24, the DSAMH data cannot be directly compared since their data are admissions, not unique individuals as in the Medicaid data. However, it is the case that the number of young adults receiving Medicaid diagnosis/treatment services has also declined somewhat, particularly for those 22-24.

Table 5 shows the youth and young adult clients receiving treatment services by county in Delaware in each or 2017 and 2018. The percentage by County is not far different from the overall population percentages by county, with New Castle County accounting for 65% of the youth statewide. The fact, though, that the percentages served are commensurate to the population in each county suggests that the problem of substance abuse is not county specific.

Table 5. Medicaid Substance Service Clients 15-24 by County

County	FY 2017		FY 2018	
	#	%	#	%
Kent	396	13%	409	15%
NC	1956	65%	1747	65%
Sussex	364	12%	347	13%
Unknown	289	10%	205	8%
Total	3005	100%	2708	100%

Table 6 shows the gender distribution of youth and young adults receiving SUD diagnostic/treatment services. Women slightly make up the majority of youth and young adults receiving services, amounting to 51% in FY2017 and 52% in FY2018. This is noteworthy because it has usually been more boys/young men than girls/young women in treatment as seen for youth in the DPBHS data (Table 2) or for young adults in the DSAMH data (Table 3).

Table 6. Medicaid Substance Service Clients 15-24 by Gender

Gender	FY 2017		FY 2018	
	#	%	#	%
Female	1528	51%	1396	52%
Male	1477	49%	1312	48%
Total	3005	100%	2708	100%

Table 7 shows the cross-tabulation of age group by county. These numbers in Table 7a are suggestive of those who are potential clients for a continuation of services following their SUD services through Medicaid. For example, the number age 15-17, the target ages for a recovery high school, is 436 in FY18. Table 7b, which shows the percentages by county, again emphasizes the point that those receiving substance use disorder services through Medicaid coverage are present in each county and roughly proportional to the population of each county.

Table 7a. Medicaid Substance Service Clients 15-24 by Age Cohort and County (Counts)								
County	FY 17				FY 18			
	Age Cohort			Total	Age Cohort			Total
	15-17	18-20	21 and greater		15-17	18-20	21 and greater	
Kent	35	87	274	396	45	101	263	409
NCC	406	500	1050	1956	315	479	953	1747
Sussex	59	108	197	364	60	101	186	347
Unknown	26	49	214	289	16	48	141	205
Total	526	744	1735	3005	436	729	1543	2708

Table 7b. Medicaid Substance Service Clients 15-24 by Age Cohort and County (%)								
	FY 17				FY 18			
	Age Cohort				Age Cohort			
County	15-17	18-20	21 and greater	15-24 Total	15-17	18-20	21 and greater	15-24 Total
Kent	7%	12%	16%	13%	10%	14%	17%	15%
NCC	77%	67%	61%	65%	72%	66%	62%	65%
Sussex	11%	15%	11%	12%	14%	14%	12%	13%
Unknown	5%	7%	12%	10%	4%	7%	9%	8%
Total	100%	100%	100%	100%	100%	100%	100%	100%

One important finding in the results from the Medicaid data involves the substances being diagnosed and treated. Table 8 below shows the drugs for which the clients are being treated, and the results are somewhat surprising. Marijuana is the primary drug of abuse by far for which clients are getting services, but opioids are second, more frequent than alcohol. It should also be noted that the fourth most common SUD drug reported is cocaine, which appears for about 10% of the youth and young adult clients.

Table 8. Types of Substance Use Disorder (SUD) Medicaid Clients Treated For*

Types of SUD	FY 2017		FY 2018	
	#	%	#	%
Alcohol	742	25%	603	22%
Opioid	1048	35%	922	34%
Cannabis	1860	62%	1690	62%
Sedatives	129	4%	117	4%
Cocaine	285	9%	310	11%
Other stimulates	80	3%	47	2%
Hallucinogenic	37	1%	34	1%
Inhalants	16	1%	11	0%
Other psychotics	346	12%	300	11%
Total	3005	100%	2708	100%

** Types of SUD sum to more than 100% as many clients had more than one type of SUD*

Since the Medicaid data allow clients to report SUD diagnosis/treatment for more than one kind of drug, both the raw numbers in Table 8 total and the percentages in Table 8 add up to more than the cases and total more than 100% for each of the FY17 and FY18 numbers. Table 9 below makes this point more clearly and shows that most (70%) clients are involved with abuse of only one substance. However, 30% are being treated for more than one substance and even a few clients are being treated for 5 or more substances.

Table 9. Number of Different Substances Medicaid Client Diagnosed/Treated for

# of types of SUD	FY 2017		FY 2018	
	#	%	#	%
1	2091	70	1925	71
2	513	17	447	17
3	238	8	192	7
4	118	4	94	3
5 or More	45	1	50	2
Total	3005	100	2708	100

More opioid treatment was encountered than expected in the Medicaid data with over a third receiving services for opioid use, so we asked CCRS to do a breakdown of drug of abuse by the same age group classification shown in Table 7. The results are shown in Table 10. Because even for de-identified data, DMMA does not allow reporting of cross tabulations where a cell size is less than 10 cases, only alcohol, marijuana, and opiates are consistently reported in the cross tabulations. As can be seen, and not unexpectedly with the known progression of drug use from marijuana and alcohol to harder drugs such as opiates and cocaine, most of the drug involvement for those 15-17 diagnosed and treated involves marijuana. About 80% of those SUD services in each year in the 15-17 age group is for marijuana. Concomitantly, there are relatively few instances of opioid diagnosis and treatment services for those 15-17 -- only 20 cases in FY2017 and 16 cases in FY2018. However, the number grows for those 18-20 to 133 cases in FY2017 and 122 in FY2018. And for those 21-24, 895 were diagnosed/treated for opioids in FY2017 and 784 in FY2018. For those 21-24, the numbers for opioids are as great as those for marijuana. The substance that is not age specific is alcohol. About 20-25% of those getting SUD diagnoses/services in each fiscal year for each age cohort are getting them for alcohol abuse.

Table 10. Types of Substance Use Disorder (SUD) of Medicaid Clients by Age Group for each of FY2017 and FY2018*

	FY 2017					
	Age Cohort					
	15-17		18-20		21 plus	
Type of SUD	#	%	#	%	#	%
Alcohol	131	25%	172	23%	439	25%
Opioid	20	4%	133	18%	895	52%
Cannabis	419	80%	555	75%	886	51%
Sedatives	12	2%	27	4%	90	5%
Cocaine	Numbers too small to report by age group					
Other stimulates	Numbers too small to report by age group					
Hallucinogenic	Numbers too small to report by age group					
Inhalants	Numbers too small to report by age group					
Other psychotics	54	10%	69	9%	223	13%
Total in Age Cohort	526		743		1736	
	FY 2018					
	Age Cohort					
	15-17		18-20		21 plus	
Type of SUD	#	%	#	%	#	%
Alcohol	91	21%	157	22%	355	23%
Opioid	16	4%	122	17%	784	51%
Cannabis	341	78%	546	75%	803	52%
Sedatives	Numbers too small to report by age group					
Cocaine	Numbers too small to report by age group					
Other stimulates	Numbers too small to report by age group					
Hallucinogenic	Numbers too small to report by age group					
Inhalants	Numbers too small to report by age group					
Other psychotics	61	14%	70	10%	169	11%
Total in Age Cohort	436		729		1543	

**** Types of SUD sum to more than 100% as many clients had more than one type of SUD***

Putting the Medicaid data together with each of the data from DSAMH and DPBHS would allow us to provide non duplicated estimates of the number of individuals by gender and age. The data systems at DSAMH do not, at present, allow for easy access to MCI numbers needed for comparisons with Medicaid and estimates of unduplicated cases nor do they currently allow for cross referencing adult cases that may also be in the Medicaid data base. However the data for youth from DSCYF do allow for this cross-referencing, and, using the ability of CCRS to do matching behind the firewall using the unique state Master Client Index (MCI) identifier, we have been able to look at clients in the DSCYF/DPBHS data base to see if they appear in the Medicaid data. The relevant years we compared are for FY17 and FY18. These data are shown in Table 11 below.

Table 11. Youth in the DSCYF/DPBHS Database for Substance Abuse also in State Medicaid

DPBHS Data	# of Clients	# in Medicaid SUD		Any Medicaid Claim	
		#	%		
FY18	120	71	59%	92	77%
FY17	163	92	56%	125	77%

Medicaid SUD Clients 15-17	# in DPBHS		
	#	#	%
FY18	436	54	12%
FY17	526	73	14%

There are some issues with missing MCI numbers in one or the other of the data bases, but most of the cases reflected in Table 2 above from DSCYF/DPBHS are reflected here. It is apparent that, as would be said in a school math class, there are quite substantial differences here between union and intersection. It has already been noted that less than 10% of the number of cases in the Medicaid data of those under 18 appear in the DSCYF/DPBHS data. It is also the case that virtually all of the cases in the DSCYF/DPBHS data were expected by DPBHS to also be in the Medicaid data (since FY2017 at least, cases are to be referred to Medicaid for payment and accounting, and the first 30 outpatient units are to be covered in Medicaid). However, it appears that only about 60% of the clients in DSCYF/DPBHS also appear in the Medicaid system for substance use disorder services, and only a little over three-quarters are appearing for any claim in Medicaid. Concomitantly, only about 13% of substance abusing/receiving services youth seem to be full represented in the intersection of the two data bases.

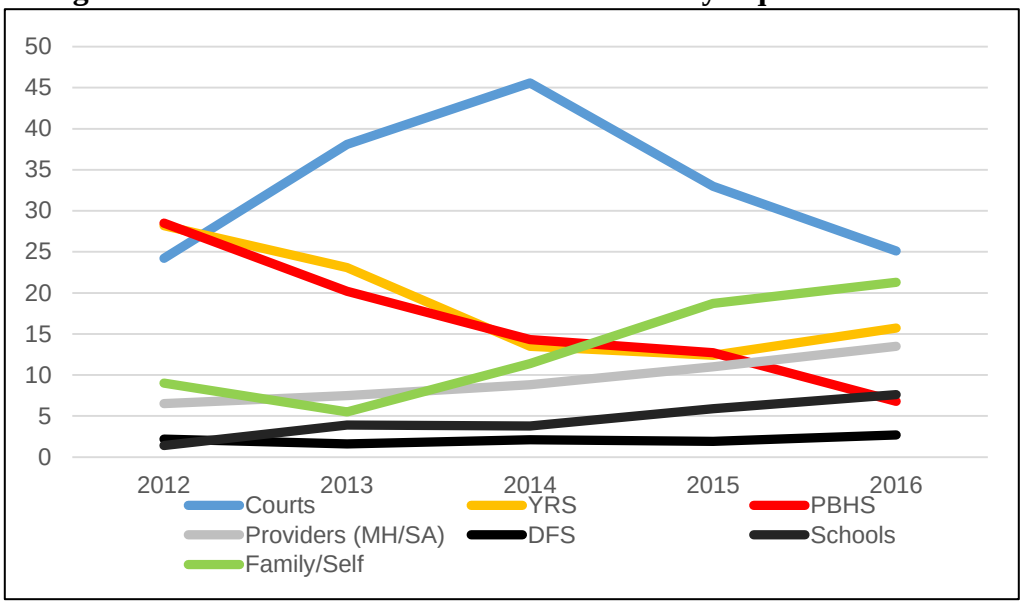
Even having the limited ability to look only at the DSCYF data in conjunction with the Medicaid data, it appears that there are a substantial number of youth receiving services for substance abuse who are not reflected in State numbers from DPBHS. The numbers may not be large in an absolute sense but they do indicate an incidence commensurate or more to what we observe among those with rare diseases or physical disabilities to which public health has wanted to provide accommodations and services. This suggests more potential need and demand for recovery services than was originally thought among Delaware youth and young adults. This perception came from a seeming sharp drop in recent years of youth in state supported treatment services.

There is evidence of adolescent substance use having been relatively steady or declining somewhat in Delaware in recent years, as discussed earlier with the student surveys and seen in the data from Figures 1-3. However, this does not begin to account for the dramatic decline in those in treatment with the state DPBHS, as reflected in the DSCYF/DPBHS data. According to the DSCYF/DPBHS data, the count of adolescent clients in publically funded treatment for substance abuse dropped by about 75% from 2012 to 2017. The drop just from 2016 to 2017 was almost 30% (see Table 2). The state convened a Substance Abuse Referral Action Committee (SARAC) in spring

2018 to investigate and seek explanations for declining substance abuse treatment admissions within the state's-network of contracted providers. Looking first at the National Survey on Drug use and Health, the Committee noted the national finding that drug use was declining fastest since 2012 among teenagers that are (a) primary marijuana, (b) treated at the outpatient level, and (c) without a prior treatment history of treatment. The committee's investigations produced two major conclusions: 1) The biggest declines involved outpatient cases where marijuana was the primary drug of abuse; and 2) the identification and referral of adolescents from the DSCYF Divisions of Prevention and Behavioral Health and Youth Rehabilitative Services plummeted.

SARAC participation included that of Aquila, the major and now virtually only contracted provider of youth treatment and rehabilitative services in the state. It is important to note that the number of juvenile treatment providers in the state declined from several to only one. And even within Aquila, the decline in clients was precipitous, but the source of the referral declines is very suggestive, as seen in data Aquila provided to SARAC for the years 2012 through 2016 (Figure 5).

Figure 5. Distribution of all referrals received by Aquila 2012-2016



Whereas the referrals from schools, the Division of Family Services (DFS), and from other providers were steady or even rising slightly, and the referrals from family/self-referrals rose quite steadily, the referrals from the Courts and from Division of Prevention and Behavioral Health Services (PBHS) declined. The decline was particularly sharp for the courts from 2014 to 2016. The staff we interviewed at Ferris School had also pointed to the decline in "clients" due to changes in Court referrals thought due to the changing perceptions about marijuana. These declines were offset slightly by a rise in referrals from the Division of Youth Rehabilitative Services from 2015 to 2016. It is possible that YRS made fewer referrals to substance abuse treatment because fewer youth were being arrested and charged for drug and drug-related offenses with the increasing normalization of marijuana use up to 2015, but by 2016 there began a small reversal with rises thought due to more serious drug use (opioids, even cocaine). SARAC concluded that increased public tolerance for

marijuana use may be demotivating referrals to treatment and recommended that DSCYF do more to "educate the public that medical marijuana deserves the same precautions as other pharmaceutics, and regular, non-medicinal use is still associated with risks - especially for youth with existing emotional problems." It may also be important to educate the courts based on the decline in referrals from that source.

We investigated some of these issues further in an interview and discussions with Dr. Mandel Much at Aquila. Dr. Much pointed to other dynamics leading to the decreased number of adolescents in treatment in the state system and the perception that this was due to less need. It appears that the application of the Affordable Care Act in Delaware also has had a role in the decreased number of youth in public treatment services and the concomitant perception that there is less need. Still, the change has been dramatic and, from Dr. Much's perspective, comes mostly from state agencies no longer referring youth clients to the contracted outpatient services. Aquila's client load for adolescents has decreased from 400-500 per year to 80-100 per year. The Aquila numbers are quite low as a proportion of the Medicaid clients, so it would be helpful to identify the source of the Medicaid reimbursed treatment of Delaware youth. Are these youth seeking treatment from private physicians and psychologists? Most of Aquila's work is now with young adults through their ARGO program for those 18 and over with substance abuse and or mental health needs. It is an intensive outpatient program with both day and evening sessions and easily involves many more clients now than their programming for those under 18. The testimonials to Aquila services on their website now refer entirely to the ARGO program, a marked change from 5-10 years ago. Dr. Much informed us that, 5 years ago, Aquila partnered with *atTAcK addiction* in writing a grant proposal to create a recovery high school in Delaware. The proposal was not funded.

Besides the review and analysis of the quantitative data sources, the potential need for treatment services should be considered qualitatively at the personal level in the reports of individuals and families searching for and reporting they cannot find the help they need in Delaware. We talked to a number of individuals and organizations working in the community in need of treatment services who cannot find help. It is important that these testimonies from those most directly impacted by substance abuse and the limits of services have the opportunity to be heard. This information is not simply anecdotal, it is the voice behind the quantitative data coming from key informants in the community and as much a part of the story as the aggregate counts and percentages. This includes summary of information from interviews with members and leaders at *atTAcK addiction*. We have found near consensus in our interviews with parents and treatment providers that services available for youth are very limited in amount and scope. There is no adolescent residential treatment available and outpatient treatment is limited with fewer providers available in the state than in previous years. A consistent and critical need mentioned by state leaders, community advocates and parents is the extreme shortage of juvenile psychiatrists and psychologists, even mental health clinicians. And for those who do find a clinician or placement (in patient necessarily is out-of-state) the path to re-entry to school and the community is difficult. Youth in substance abuse treatment or returning from treatment feel unwelcome, stigmatized and unsupported in the regular school environment. When we met with Dr. Rebecca Richmond and other Ferris/Detention Center staff in March, they also stressed the difficulties youth who have

been detained at Ferris have in returning to their former high schools. They reported on some youth who had made progress in their education while at Ferris, but who had difficulties being accepted back into their high school. Clearly, additional services are needed to ensure academic engagement and to prevent relapse. It is not clear, however, that a Recovery High School will best meet these needs in Delaware. Here we review models and services that have been applied in other states.

2.) Look at the best models for Recovery High Schools that have been in operation nationally, talk to researchers and policymakers who have studied and supported these efforts, and report on the utility of the Recovery High School movement nationally

THE RECOVERY SCHOOL MOVEMENT

Recovery high schools (RHSs) are part of a broader movement to create communities of support for people in recovery from alcohol and drug use (White and Finch, 2006). This movement includes 12-step programs, sober living residences, collegiate recovery programs, faith-based recovery support groups, and employment enterprises such as restaurants or moving companies operated by men and women in recovery. The supportive community approach is a response to high relapse rates documented for clients following substance abuse treatment. It views addiction holistically from a systems perspective rather than a problem solely within the individual struggling with substance use problems. Although adherents to this model may agree that addiction is a disease, they also argue that it is a social problem and not just a biological and psychological disorder. William White summarizes this position:

> The acute care model of addiction treatment provides an opportunity for recovery initiation but may or may not exert an influence on the process of recovery maintenance. A growing number of "system-sophisticated" clients have acquired skills in recovery initiation (e.g., "doing treatment") but repeatedly relapse due to their failure to make the transition to recovery maintenance in natural, non-institutional environments. What is needed in such circumstances is not an unending series of treatment episodes (more recovery initiation), but a focus on building the personal, family, and community recovery capital required for long-term recovery maintenance. That process requires interventions at the individual, family, and community levels" (White 2009: p.151).

Unfortunately, youth in recovery tend to also experience the cycles of treatment and relapse described by White. While large-scale clinical trials have demonstrated short-term substance reduction and/or cessation, "adolescents with substance use disorders, even with the best evidence-based care, rarely achieve long-term abstinence" (Gray and Squeglia, 2018: p.624).

Recovery high schools are schools designed to meet ongoing needs of students recovering from substance abuse issues. The Association for Recovery Schools lists forty recovery schools throughout the United States, not all of which are still in operation from our calls. Most recovery

schools are concentrated in just four states --California, Texas, Massachusetts and Minnesota. Currently, Delaware does not have a recovery school, and the closest recovery school is in Philadelphia. Although several Delaware students have attended the Philadelphia school, they struggled with tuition and transportation issues, and one student left the program without graduating. RHSs allow adolescents in recovery to be surrounded by peers, teachers and staff who support recovery efforts and attitudes. Recovery school students may have recently completed substance abuse treatment, or they may be in concurrent treatment for substance use or other mental health problems. Recovery high schools tend to be much smaller than conventional schools. Typical enrollment is less than twenty students, but some schools have fewer than ten while a few have 60-75 students. Several experts we interviewed noted it is hard to stay on top of each child's recovery in larger programs.

Because recovery schools are so small, they tend to employ only a handful of teachers and cannot offer the full range of course offerings available in conventional high schools. Instead, recovery schools tend to employ one or two certified teachers in each general subject area (e.g., math, language arts), and these teachers monitor and facilitate students' participation in accredited online instructional programs. In our interview with Dr. Andrew Finch, co-founder of the Association for Recovery Schools, he noted that the small number of certified teachers in recovery high schools can be assisted by administrators who also teach and by non-accredited staff who supervise and support students as they take on-line classes (Finch, 2019).

Many recovery school students are behind grade level due to past academic difficulties and school absence, so the academic focus in the RHS is often on credit recovery of graduation requirements. Although several educators we interviewed endorsed allowances such as a reduced course load and a no homework policy to reduce stress for students in recovery and to allow sufficient time for continued substance abuse and mental health treatment, they simultaneously rejected a shortened school day arguing that unsupervised, unstructured time would threaten adolescents' recovery. Parents and experts we interviewed expressed that the shortened school day of most alternative schools and exposure to peers who are not committed to recovery make existing alternative schools in Delaware unsuitable for recovering students.

Recovery high schools are too small to offer many extracurricular programs. While alternative high schools sometimes compensate for this by allowing students to participate in athletic and other extracurricular activities at their previous assigned high school, this practice is discouraged for recovery high students. Instead, recovery schools offer "Alternative Peer Groups" in which recovering students can socialize and support each other by meeting for substance-free informal activities such as movie or game nights or adult chaperoned weekend outdoor trips. Some recovery schools designate adult staff to facilitate the Alternative Peer Groups. Recovery high schools may coordinate with structured after-school recreational and community service programs under the auspices of community organizations such as Boys and Girls clubs. Some recovery high schools also coordinate with substance abuse treatment providers so that students spend after-school and weekend time in individual or group therapy focused on relapse prevention. Clinicians we interviewed were wary of youth attending general 12 step groups such as Alcoholics Anonymous

or Narcotics Anonymous. These general self-help groups are risky because youth would mingle with older adults who are at a developmentally different stage, may be court-mandated but still using substances, and may make inappropriate overtures to naive and vulnerable youth.

Most RHSs require students to submit to periodic drug tests, but they differ in their policies regarding how to handle students who test positive for drugs. Since addiction is a chronic disease, and relapse is common, RHS administrators are reluctant to expel students who have a setback in their recovery. On the other hand, allowing continued drug use by students undermines the primary rationale for the existence of the RHS— providing a safe and sober environment free from exposure to drug using peers. While researching existing RHSs we found one anonymous on-line complaint asserting that RHS students were using drugs in the immediate vicinity of the school. Turning a blind eye to student drug use can undermine community support for recovery schools.

Two RHS administrators we interviewed stated they will intervene when a student tests positive and allow the student to remain in the RHS if he or she is committed to recovery. A student with repeated positive urinalysis screenings who seems disengaged in the recovery community's efforts will likely be asked to leave the RHS. THC is the most frequent positive finding in drug tests at the two RHSs we visited. Dr. Finch does not support retaining students who test positive for marijuana unless they recommit to recovery. He stated that RHS students who continue to use marijuana are exploiting societal acceptance of the substance, but it is not healthy for the developing brain or for long-term recovery. Finch believes RHSs should allow for medically assisted substance abuse treatment possibly including non THC cannaboids, but only under medical supervision.

In addition to differing policies regarding whether to retain students who continue to use substances, RHSs' differ in their policies regarding whether to admit court-mandated or school-mandated students. Ideally, RHS students enroll voluntarily because they are committed to participating in a supportive recovery community. Involuntary students can undermine the recovery culture. Publicly funded RHSs, however, may be obligated to accept students in need of services. Dr. Finch advises it is acceptable to admit court-mandated youth if the RHS is not the *only* treatment they receive but is an adjunct to other services. He observes there is some degree of parental coercion in most RHS students' enrollments. He did state, however, that the inclusion of several recovery schools in California with court-ordered youth may have weakened the results in a multi-site evaluation study he conducted with support from the National Institute on Dug Abuse. Some of the California recovery schools are also larger than the typical recovery school, however, so it is possible that less personal attention rather than inclusion of clients with involuntary enrollments accounts for that finding.

Given the financial, logistic and programmatic difficulties of creating and sustaining a RHS, we asked Dr. Finch if it would not be better to just increase resources for recovering students in existing high schools. He responded that, "Educators are the hardest ones to convince." He sees this as part of the mainstreaming movement, but argues mainstreaming is inappropriate for recovering youth. Despite Finch's rejection of mainstreaming, at least three of the thirty-five active RHSs in the Association of Recovery Schools operate as a school within a school, and several others

appear to be specialized tracks within larger alternarive schools. When asked about the argument that such youth can't be kept in a bubble, he offered the analogy of someone who has just left the hospital with a weakened immune system and must avoid public interaction until they are stronger. He also stated that about a third of RHS students do feel strong enough to eventually return to regular high school, a third leave the RHS due to substance use or behavior problems, and a third graduate from RHS.

From our examination, there is only one published peer reviewed evaluation study that reports positive outcomes for students attending recovery high schools (Finch et al., 2018). Students who attended recovery high schools said they had used marijuana fewer days in the previous ninety days than did youth in a comparison group who were released from substance abuse treatment but did not attend recovery schools. The recovery high school students were also more likely to report they completely abstained from alcohol and drug use. However, the two groups did not differ significantly in their reported frequency of alcohol use or their use of drugs other than marijuana in the previous ninety days, so the complete abstinence effect is accounted for by the effect of marijuana. The first author of the study was co-founder and executive director of The Association of Recovery Schools. The students' self-reports of substance use or abstinence were not verified by urinalysis, and it is possible that students in recovery high schools hesitate to fully disclose their substance use. Although students were assured their interviews were confidential, most RHSs policies provide for expulsion of drug-using students, so it is possible some RHS survey participants were hesitant to disclose their substance use. Even those who did not fear disciplinary consequences may have withheld admitting substance use so as not to reflect badly on the schools that were attempting to help them and others.

Dr. Finch and colleagues recently presented 12 month follow-up data that largely replicate the results in the 2018 article— significant reductions in marijuana and nonsignificant results for other substances (Moburg & Finch, 2019).

School Profiles

RHS have been prominently featured as a treatment and education alternative for high school age youth for the past 15 years. Two recent popular review articles are that by Tulenko in the *Hechinger Report* (2017) and by Gorman in *Time Magazine* (2019). To look at some exemplar schools in more depth, the following schools are described as examples of Recovery High Schools to illustrate possible organizational structures, funding mechanisms, academic programming, relapse policies, and special challenges. These programs were recommended as exemplary schools by RHS advocates and in media accounts. We were able to visit the Bridge Way School in Philadelphia, PA and Independence Academy in Brockton, MA and interviewed their principals and some staff members. These profiles are illustrative, but not comprehensive. We also attempted via telephone and email to contact all the RHSs listed as members of the Recovery High School Association to

ascertain enrollment and staffing information. The results of those queries are summarized in Appendix A2.

Archway Academy

Open since 2004, Archway Academy in Houston, Texas is currently the largest RHS in the country with 75 students. Archway operates two programs: the traditional Archway program for students who have been sober for 60 days and have been out of inpatient treatment for over 30 days and the Passageway program for youth in earlier stages of recovery. Both programs are housed on the campus of Palmer Memorial Episcopal Church. Archway has a funding and academic partnership with The Phoenix School of Southwest Schools, a State Charter comprising programs to support students in residential treatment centers, day treatment programs and RHSs. A Venn diagram on the school website indicates that Archway Academy is primarily responsible for recovery services while the Phoenix School is primarily responsible for academic programming. Student transcripts and diplomas are issued by Southwest Schools. Although housed on a church campus, Archway Academy is an independent nonprofit 501(c) organization not affiliated with any religious organization. It does, however, follow the 12-step recovery model and requires students to actively work a 12-step program and to have a 12-step sponsor.

Students pay $1,050 per month to attend Archway and an additional $300 per year for drug testing fees. Some scholarships are available for students whose families cannot afford tuition. Tuition and fees do not cover the full cost per student at Archway. The difference between tuition and the true cost is made up by donations, state and federal education funding through Southwest Schools, the umbrella organization of the Phoenix School, and by Palmer Memorial Episcopal Church providing space. Parking is limited near the school, so students are encouraged to use public transportation. They can obtain free metro cards through Southwest Schools.

The entire student body gathers each morning for a check-in before the start of academic classes. Beginning with the third step prayer from the Alcoholics Anonymous Big Book, students are urged to commit to a higher power. Then, they report individual progress and concerns. During the check in each student shares how much time they have in sobriety. Students who are struggling may receive feedback from fellow students at the check-in and can be identified by staff as needing additional counseling to prevent relapse.

Following check-in, students attend academic classes. Each student has an individualized education plan developed by the Phoenix school. Many students are behind track to graduate due to their past substance use, expulsions, suspensions, and time out of school for treatment, so their academic program focusses on credit recovery through self-paced and online study and proficiency testing. In addition to morning check-ins and academic classes, students are required to participate in fitness and wellness activities, some longer recovery meetings, and community service activity. All students must be part of an Alternative Peer Group (APG) to enroll at Archway. In addition to vouching that students are actively in recovery and thus eligible for enrollment at Archway, the APG monitors and supports its members' progress at Archway and can recommend discipline or

termination of students who are not committed to sober living. Most importantly, the APG organizes after-school and weekend social activities so that students are not tempted by peers who continue to use alcohol and drugs. Archway Academy and the Houston APGs are featured in a popular documentary, *Generation Found*, available for viewing on Amazon Prime Video (Williams & Reily, 2016).

The Archway Academy student contract stipulates that students must consent to frequent on-campus drug and alcohol testing. Failure to provide a urine sample within 30 minutes of the request is treated as a positive test. Staff also conduct unannounced searches for alcohol, drugs, paraphernalia, or missing/stolen items. These searches cover students and their personal property including lunch containers, backpacks, cell phones, desks, purses, wallets and vehicles. Students who test positive or who are found in possession of drugs or alcohol are not automatically suspended, but must honestly confess to a slip-up and make a sincere effort to follow their recovery plan in order to remain at Archway. Several pages of the student handbook stipulate policies for calling police to the school and/or making students available to police who come to the school to investigate criminal activity. The school policy is to make the student available for questioning but to document the names and affiliations of the law enforcement officers and have a school staff member present during questioning if that is allowed.

Bridge Way School

Bridge Way School in Philadelphia has recently relocated and currently rents space in a former Catholic school building. We visited the school in March, 2019 and interviewed the school principal, Rebecca Bonner, and the director of intervention services. Although the school has a capacity of 30 students, only eight students, seven boys and one girl, were enrolled when we visited. The school's viability is threatened by declining enrollment and funding and transportation difficulties. The school has four full-time equivalent staff including the director, a full-time English language teacher, a part-time science and math teacher, and two peer specialist/recovery coaches. A part-time special education teacher visits from Chester County. One third of students have formalized Individualized Education Plans (though not all the special education services). The academic program primarily consists of online instruction with a focus on credit recovery. Between one and four students graduate each year. The school has some notable success stories including one student who went on to graduate from college, attend graduate school and join the Peace Corps.

The daily program at Bridge Way is similar to that at other schools we reviewed including an opening check-in, supervised on-line instruction, a break for physical activity, occasional evening and weekend recreational activities, and consultation with recovery coaches and the intervention specialist to review the student's recovery plan.

A pilot grant from the State of Pennsylvania was the main source of start-up funding for the school. Tuition at Bridge Way is $28,500 per year. Public high school students in Pennsylvania cover some of this cost when funds follow them from their regularly assigned school, but this is far less

than the total cost of services at Bridge Way. About 15% of students' families pay the full cost out-of-pocket. The school is able to provide some scholarship assistance. The Bridge Way website solicits donations for scholarships. Pennsylvania legislation provides tax credits to businesses that donate money to support recovery schools. Philadelphia provides free public transportation passes for students, but transportation poses an additional financial burden for suburban and out-of-state students.

The director attributed declining enrollment at Bridge Way to several factors including high tuition, transportation difficulties, a reduced neighborhood knowledge of the new location, and a decline in students leaving residential treatment facilities. She stated that four residential facilities for adolescents have closed and only a few residential facilities remain for Pennsylvania youth with substance use disorder. The opiate epidemic combined with increasing acceptance of marijuana use have led to a reluctance to hospitalize youth whose primary substance of abuse is marijuana. Thus, Bridge Way receives fewer youth transitioning out of inpatient care. Ms. Bonner plans to approach juvenile court judges to recruit additional students to Bridge Way. While this may seem counter to the traditional emphasis of the RHS as a voluntary recovery community of peers committed to sober living, she acknowledges there is usually some degree of coercion when parents enroll their children in a RHS. Juvenile court judges could require adjudicated youth to enter a recovery program while holding up Bridge Way as one possible choice.

The small enrollment at Bridge Way makes it difficult to impose severe consequences for continued drug use or other misbehavior. Students are regularly drug tested, but positive tests mainly result in renewed efforts to engage the student in working their recovery program.

Hope Academy

Hope Academy in Indianapolis is a public charter school sited in Fairbanks substance abuse treatment center. It gets about $14,000 per student from their local school district, but the school relies on donations to make up the difference between charter school funding per student and the approximate $22,000 per year cost. In at least one recent year, the school relied on $330,000 from Fairbanks treatment facility to make up a shortfall. The school's website solicits donations.

Like Archway Academy, Hope Academy employs a 12-step recovery approach. As a condition of their enrollment, students must commit to: 1) Attend and show verification of attendance for a minimum of two group meetings a week, 2) Have a sponsor verified by Hope Academy staff, and make a minimum of 2 contacts weekly with this sponsor, 3) Engage in the use of specific recovery tools such as regular journaling activity, 4) Report relapses within 24 hours to Hope Academy Recovery Coach or Principal, 5) Be actively working one of the 12 Steps. Students who are unable to demonstrate adequate progress in behavior, recovery or academics may be remanded to the Supportive Therapeutic Action-focused Recovery Room (STARR) for a minimum placement of three weeks before being readmitted to regular classes.

The school website lists eleven staff members including a principal, chief operating officer, enrollment specialist, administrative assistant, five teachers, a recovery coach, and an art instructor who also serves as a STARR facilitator. Hope students earn a high school diploma that meets all Indiana college admission standards. The curriculum is delivered in a combination of small classes and online instruction via the PLATO@ platform. In addition to academic classes, students are offered intensive college and career counseling, recovery coaching, and life skills instruction (e.g., check book balancing, job applications, interviewing skills). A majority of Hope Academy graduates attend college or other post-secondary education.

Hope Academy has addressed enrollment challenges by hiring an enrollment specialist, emphasizing its free tuition, and providing transportation to Indianapolis students on two bus routes with a total of eight drop-off/pick/up sites throughout the city. The current enrollment at Hope is about 25 students with a student/teacher ratio of 4/1.

Independence Academy

Independence Academy in Brockton, MA, the fourth RHS in Massachusetts, opened in 2012 (Myers, 2013). Located in a 9,000 square foot remodeled school building, the school currently enrolls 22 students. Independence Academy accepts students up to age 21 and offers dual enrollment with Massasoit Community College. The school was created with $2,500,000 in startup funding and receives $500,000 per year from the Massachusetts Department of Education. In addition to the Department of Education funding, the school receives approximately $11,000 per year tuition for each student from the student's home school district. Independence Academy can serve students from sixteen different school districts in southeastern Massachusetts, but transportation difficulties often deter students from attending. In an effort to address both transportation challenges and insufficient tuition payments from students' home school districts, State Representative Liz Malia filed H518, An Act Strengthening Recovery High Schools. This proposed legislation would require transportation to be provided and increase the cap on tuition to two and a half times greater than the current cap. H518 was heard by the Education Committee in June, 2019, but has not received a final vote.

The regular school day runs from 9:00 to 3:30 with a break for physical activity in the weight room or outside and yoga for a half-hour at the end of each day. A 30-minute recovery group is led daily by the school's addiction counselor. In their first three months, students must also attend intensive group therapy sessions three times a week. These run after the regular school day from 3:30 to 6:30 p.m. Students sign enrollment contracts promising to remain sober and agreeing to random drug testing. Principal Ryan Morgan reports that students are generally tested twice a month and the majority of drug tests come up positive, primarily for marijuana. While students can be suspended for continued drug use, students who relapse may remain in school if staff determine they are still engaged in school activities and committed to recovery.

Rockdale Recovery High School

Rockdale Recovery High School in Worcester, Massachusetts opened in 2015 in a newly renovated space designed exclusively for recovery high school students. The school is intended to serve all of Central Massachusetts. It is partially funded with a $2.25 million grant from the Massachusetts Department of Public Health. The school also charges tuition to the students' sending districts. The annual budget is $500,000 plus $250,000 from the state for transportation.

Although enrollment is capped at 50 students, the school has never had that many. It ended its first year with 31 students and started the 2016-17 school year with 14 students. The school enrolled 15 students in fiscal year 2018 (Massachusetts Department of Public Health, 2018). A teacher's blog on the school website in 2019 stated, "Enrollment has been down this year at Rockdale; we must reverse this trend. To increase awareness, we are starting a blog"

The school's staff of seven includes four teachers of English, math, science and social studies. Classes are rarely larger than five or six students. The school day starts with a group meeting where students talk about about their recovery, challenges that they encounter, and barriers that they feel might interfere with their classwork. Students who express significant issues in this group meeting will be connected with the recovery counselor.

Rockdale was the subject of a Nightline Episode in November, 2017 that featured three of the students struggling to maintain sobriety. Although Rockdale's website states students must be clean for 30 days before attending the school, the Nightline profiles appear to contradict this. Local newspaper stories suggest the school grapples with promising a safe, drug-free environment for recovering students while deciding how to manage relapse. Marijuana has proved particularly vexing as a large percentage of students test positive for the substance, but expelling them could reduce the school population to a point that it could no longer operate. Massachusetts has legalized recreational marijuana use for adults. While cannabis is still illegal for minors, it is readily available and perceived as relatively safe or even beneficial. Several Rockdale students who tested positive for marijuana avowed that this substance was necessary to prevent them from using opiates (O'Connell, 2016).

First State School (a Delaware model)

Finally, while it is not a recovery high school for youth with substance use disorder, several parents from *atTAcK addiction*, pointed to Delaware's First State School as a model for how an RHS could be established here. First State School gives children and adolescents who would otherwise be homebound with serious illnesses the chance to attend school with their peers while they get the medical treatment they need. Located at Wilmington Hospital, First State School offers kindergarten through high-school education to children with diabetes, sickle-cell anemia, severe asthma, cancer and other illnesses that preclude attendance at regular school.

It is a collaboration between Christiana Care and the Delaware Department of Education through the Red Clay School District. Teachers are state-certified employees of Red Clay School

District, and they provide instruction in accordance with the student's Individualized Education Plan (IEP) and the Delaware State Content Standards. The First State School staff, including physicians, nurses, educators and psychologists are available throughout the school day to oversee each student's daily needs in collaboration with their family and primary care physicians and subspecialty consultants. The school's web page lists four teachers in a total of twenty staff. Three students graduated in 2017. In the beginning, First State School served only high-school students. The program was expanded in 1991 to grades K-12, with students age 5 to 21.

The parents from *atTAcK addiction* whom we interviewed felt their children suffering from substance use disorder deserve the same attention and level of services that the First State School provides to children with severe physical illnesses and disabilities. If the funding, facility, and administrative challenges can be met to sustain the First State School, these parents wonder why a similar commitment is not made to youth in substance use recovery?

3) Existing resources (champions, federal state and local instrumental support) and barriers (cost, location, logistics, sustainability) to both establishing and maintaining a recovery high school and other programs in Delaware

Virtually all of the logistical problems experienced in Recovery High Schools in other states described above would exist in a Delaware "brick and mortar" school (or schools), and in many ways the problems would be compounded in Delaware. Problems of appropriate ages of students for a school (e.g., should they be only high school age or should young adults who had dropped out of school be included to come back and finish their degree?); zero tolerance for drugs (e.g., drug testing or not, how often, consequences of failed tests?); educational provisions (e.g., how many teachers, how to use online curriculums, how to establish credits with a district or the state, need for teachers certified in special education); access to extracurricular activities (is it appropriate for RHS students to mix with other students for extra-curricular activities or should students be purposely isolated from contact with peers who may have supported their drug use?); and of course transportation for a non-residential school (e.g., vans covering how great a territory, family responsibility to get student to school?). Most of the RHS sites we visited, talked to, or explored online exist in urban settings with a potential client population as large or usually larger than Delaware as a whole in a relatively compact geographical area with at least manageable public transportation. As seen in section 1 of the Report, Delaware has a number of youth with SUD who might benefit from a recovery high school, but they are distributed all over the state and not particularly concentrated in specific areas. With the changing demographics, it is likely there are unused buildings in Delaware (former schools) that could be used for recovery high schools, and they likely exist even in each county; however, it is less the availability of buildings, and even the funds necessary for startup modifications (e.g., ADA accessibility and compatibility, internet access, furnishings, computers, fire safety, utility upgrades, health and nursing space, lunchroom, physical education space, etc.) that are the long term problems The schools must meet DOE criteria as educational facilities and DHSS rules for health and safety, and that requires access to specialized staff. RHS have low staff/client ratios in any case, but the specialized requirements may mean ratios

of 3/1 when most schools have 20-30/1. This is not an insurmountable issue, and it can be considered as schools do for dealing with those with a disability or chronic health problem. Charter schools in the state have confronted these issues, and some have succeeded in circumstances where they fill a needed gap in education in their community location, have community advocates, and can get the right number of appropriate students to the school.

We discussed the potential logistics of instituting one or more recovery high schools in Delaware with both state administrators and community activists. On the state education side, we talked with Dr. Christine Alois, Deputy Secretary, Department of Education. It appears DOE is sympathetic to the need for services to help substance involved youth with their recovery and education. However, DOE is wary of the costs and the difficulties in meeting federal and state mandates for services available to students in publicly supported schools. ADA and other statutes would come into play. DOE would want collaboration in establishing how the educational standards would be stated and who would monitor them. It is unclear if such a school could be set up within a District or would need a state "charter." It would require a real partnership between not simply the state agencies, DOE, DSCYF, DPH but also champions in each of these state Departments and Divisions, as well as legislative champions. DOE is also very aware of the political issues of a physical school which would be perceived to favor the part of the state where it was located.

Also on the state side, we met with several of the educational and treatment staff at the Ferris School in March, Dr. Rebecca Richmond, supervisor for Psychological Service, Richard Lee, the Principal for educational services, Dr. Linda Friedman, DSCYF Psychologist, Sarah Ciano, Nurse, and others. In some ways Ferris operates with some of the characteristics of a recovery high school, providing both recovery counseling and high school educational services in a sober environment away from outside influences. The population at Ferris is quite a bit down from its high points, and the population is younger. The clients at Ferris were at the time of our visit 100% substance involved, mostly marijuana. Only a few clients at the time were opiate abusers, in fact they were seeing more of a resurgence of cocaine rather than opioids in the Ferris population. Most Ferris students have mental health issues as well as substance abuse. Dr. Friedman said that Delaware has a tendency to compartmentalize mental health services from substance abuse services, and the state needs to get beyond the either/or approach currently used by the state. Ferris has 4 transitional specialists working with re-entry issues and they use the YAP (Youth Advocates Program) to help youth transition back to the community, but only 5 or 6 students have been willing to be involved. Ferris staff said a big issue for a RHS would be an issue they face at Ferris: the lack of positive youth and family motivation for return to community. The kids are still under 18, often only 15 or 16; they do not have a long history of use and relapse; they do not think they have a problem; they do not see the value in programs like YAP, and many would not see the value of a RHS. The regular schools do not want them back and make it hard for them to return. Without a lot of preparation and education, it would be hard to have a recovery track in a regular school; kids would not want to be labeled as being in the "recovery track" at a high school just like kids at Ferris do not want to be labeled as being in the "trauma track." They thought an expansion of "school counselors" who could deal with a variety of issue from college admissions to drug and mental

health counseling might be better because kids would not be identified on what kind of counseling they were getting.

We also talked about the needs and logistics of a recovery high school with Ms. Rebecca King, Nursing Director for the Division of Public Health in the Department of Health and Social Services. She highlighted the particular need in the state for inpatient treatment for youth with acute SUD. She recommended viewing the recovery needs of SUD students as akin to healing from a traumatic injury. She advocated for better youth assessment. She also discussed logistic issues specific to her expertise, both in her current role and in her previous role with the Red Clay School District. Given the recovery nature of such a school, both the on-site nursing and counseling needs for students as well as the appropriate health services back-ups are of concern. Depending on location, students might have access to a nearby high school wellness clinic. Ms. King wears at least two hats, and as a board member of *atTAcK addiction*, she has thought long about recovery high school options, and suggests that the principles and services but not the physical stand-alone school may be more what is needed and, more importantly, can work in Delaware.

We also discussed recovery high schools extensively with key leaders at *atTAcK addiction*, both at the beginning and the end of our data gathering efforts. This was important because the organization had been instrumental in the state's interest and their decision to study the prospects for a RHS in Delaware. In March 2019 when we met with *atTAcK addiction*, the leadership was very much in support of a RHS in Delaware, as seen in their pamphlet from 2017 in Appendix A3. They were disappointed that the state had chosen not to pursue funding a school using a building offered by the Red Clay School District (Gorman, 2019). They felt that an opportunity had been missed and it was better to do something now to help those in immediate need, several of whom had reached out to the organization for help. They were not happy that nothing would be done until our report was put out near the end of the year. When we met with *atTAcK addiction* leadership again in September 2019, their attitudes seemed to have changed. They maintained they did not want a brick and mortar formal RHS, in fact they said that had never been their intention. They recognized many of the difficulties, particularly the location, transportation, appropriate client selection, and operation of drug testing. They did feel that the state needed to improve the acute services available for youth, including residential programs in state. They also wanted to use facilities, perhaps at existing schools to have RHS-like programs. This would allow some access to traditional school facilities, but they maintained a strong feeling that the programs for recovering youth and their education should be mostly separate from the regular school and association with regular students.

If Delaware decides to pursue a recovery high school, there are several good technical assistance resources the state can draw upon. Most direct is the STR-TA Consortium that SAMHSA sponsors through the Opioid Response Network of the State Targeted Response as operationalizing the 21st Century CURES Act. Delaware is a participant in the STR. We talked with Ms. Kristen Harper, now at the Center for Social Innovation (CSI), but previously Executive Director of the Association of Recovery High Schools. CSI is the SAMHSA contractor who would be the lead on any

TA requests the state might make (STR website. https://getstr-ta.org/index.aspx). Her contact information is included in the references.

4) Examination of alternatives that should be considered by the Behavioral Health Consortium (BHC), community champions, and other policy makers in Delaware to provide needed services for the dual goals of recovery and education.

Given the funding and enrollment difficulties encountered by RHSs in other states, Delaware should consider some alternatives that could provide needed services to youth in recovery without creating a separate school. Although Delaware has more than enough students who meet criteria for substance abuse disorder and may have unmet educational needs, it is difficult to see how this state could be more successful than major metropolitan areas such as Philadelphia and Boston that struggle to maintain enrollments in their RHSs. The experts we interviewed stressed the need to create a strong financial model and sustainable funding stream *at the outset* if Delaware chooses to start a RHS. Administrators we spoke to were dispirited by the time and effort they spend lobbying and fundraising to keep their school afloat. Delaware will need to make a large financial commitment to a precarious enterprise if it establishes a stand-alone RHS. Perhaps this could be accomplished with a windfall from federal funding, pharmaceutical company settlements (people hope for something like the Master settlement made with Big Tobacco), or a philanthropic benefactor; however, it would be difficult for the state to make the necessary commitment from taxpayer funds for a start-up operation, which would then face the difficulties of sustainability. For these reasons, Delaware should consider some alternatives to a traditional RHS. We discuss some of these alternatives and their advantages and disadvantages below.

Recovery Track Within One or More Existing High Schools

A recovery track within one or more existing public high schools may be more feasible than instituting a stand-alone RHS. We see a number of financial, logistic and programmatic advantages to this approach. Most of the RHSs we reviewed serve fewer than thirty students. It would be expensive to obtain and maintain a separate facility for so few students. Some RHSs have space donated by treatment or faith organizations, while others have built facilities with large start-up funding from their state. In Delaware, there are currently some unused and underutilized school buildings that could be provided for a RHS, and some district funds would follow each student who "choiced" into a RHS. Still, the janitorial, utility and maintenance costs for a separate building and state-mandated staffing requirements (e.g., a school nurse, guidance counselors for academic/career planning) would make it prohibitively expensive to operate a stand-alone RHS. Further, state and federally mandated reporting requirements (finances, enrollment, special needs, discipline and expulsion, achievement testing) could overwhelm a single administrator of a stand-alone RHS. These expenses and functions would already be covered in a regular high school, so that

any additional resources could be concentrated on recovery services for students rather than building, administrative and ancillary services costs.

Logistically, a recovery program in one or more existing high schools would avoid many of the transportation issues that have plagued stand-alone RHSs. Although several schools have attempted to redress the problem by providing public transportation passes or operating their own vans to transport students between home and school, these accommodations strain the finances of a RHS. Our needs assessment indicates demand for recovery support services for youth in each of the State's three counties. It would be most fair to offer recovery support services in an existing school in each county rather than concentrate all resources in New Castle County and requiring long commutes for downstate students.

Another logistical advantage to creating one or more recovery communities within an existing high school or schools is that this approach provides maximum flexibility for expansion, retraction, or reassigning staff to respond to changing demand. The counselors and teachers hired for a recovery track could switch their focus to regular classroom teaching, counseling and prevention activities if fewer students enroll in the recovery community in subsequent years. Also, staff could be reassigned to meet increasing or decreasing demand in particular schools.

Finally, we see programmatic advantages of siting recovery services in existing high schools. Foremost of these advantages is being able to offer a greater breadth and depth of academic programs. Most of the stand-alone RHSs we reviewed have very few teachers and rely heavily on computerized instruction. Teachers monitor and assist students as they progress through the on-line curriculum. While this may be necessary in order for so few teachers to instruct students with diverse aptitudes, grade levels, and achievements, it seems unlikely to provide the interest, interaction, engagement and richness of a regular classroom experience. Students can become bored if only interacting with a computer and the same small group of peers throughout the day. Further, many students with SUDs also experience learning disabilities or ADHD, and it is unlikely computerized instruction and two or three general area teachers could meet their special educational needs.

In addition to greater breadth and depth of academic curriculum, existing public schools can offer a full range of extracurricular activities including athletics, music, special interest clubs and community service groups. RHS advocates we spoke to expressed strong reservations about recovering students socializing with former peers who encourage alcohol and drug use, and they suggested that these extracurricular activities are too risky for recovering students to engage in. On the other hand, several parents acknowledged that recovering students "can't live in a bubble forever. " We believe a strong recovery community in the high school could help students navigate the transition and temptations of interacting with non-recovering peers. While many extra-curricular activities might be inappropriate for a student in the very early stages of recovery, a well-staffed and supportive recovery community could help youth determine how and when to reengage with a larger peer group, strategize ways to handle temptations that arise, and quickly intervene if a student succumbed to enticements.

In fact, except for closed residential facilities, RHS schools are unable to provide the substance-free environment that is so hoped for. Substance abuse disorder is a chronic, relapsing condition, so it is unsurprising that most of the RHS schools that require drug-testing find a substantial number of their students testing positive for illegal drugs. In the previously cited RHS evaluation studies by Finch and colleagues, the self-reported alcohol and drug use of RHS students *exceeds* that of high school students in general surveys such as The National Survey of Drug Use, the Monitoring the Future Survey, and Delaware School Surveys. On average, the RHS students in that study said they used marijuana nine days in the previous three months. The general high school population poses no more exposure to substance use than fellow RHS students. This does not contradict or negate the significant finding that RHS students report less marijuana use than do youth who leave treatment but do not attend a RHS. In that evaluation study, the comparison is to youth who either leave school or attend a school without a recovery community. RHS students may hesitate to acknowledge a relapse, so a stronger evaluation would include bioassays. Independence Academy RHS in Brockton, MA drug tests students about twice a month. When asked what percentage of the drug tests are positive, the principal Ryan Morgan replied, "Most of them." There is no certainty that a stand-alone RHS can provide less exposure to substance-using peers than a recovery support community within a general high school.

Ryan Morgan expressed a different reservation about including a recovery community within a general high school— a lack of understanding and flexibility on the part of teachers and administrators who might hold judgmental attitudes and enforce rigid discipline over trivial issues such as school dress codes (Morgan, 2019). He believes youth in recovery need greater leeway than would be allowed in a regular school. He also stated that a regular high school might be troubled by ambulance and police visits which occur with some frequency when recovering students arrive at school high or have behavioral outbursts. Morgan believes that locating a recovery community within a larger school could only work if staff at the school are well-informed about the adolescent recovery process and strongly committed to a culture of acceptance.

A recovery track within an existing school could operate as a hybrid model blending some features of current stand-alone RHSs and collegiate recovery communities. The recovery track would be staffed by a school psychologist, special education/homeroom teacher and a peer recovery coach. The school psychologist could oversee thorough evaluations of each entering student to identify needs for substance use treatment, mental health services and special education. In addition to monitoring student progress and providing ongoing counseling, the psychologist could connect students to additional support services outside of the school such as outpatient mental health or substance abuse treatment. The special education teacher could serve as the homeroom and first period teacher for recovery track students, conducting morning check-ins and overseeing recovery and wellness related activities such as mindfulness exercises. During the remainder of the school day, some recovery track students could be integrated into regular classes while others would remain with the special education teacher in the homeroom for individualized instruction or supervised on-line classes. Students could reconvene in the homeroom during last period to review the day and identify intentions for how to remain sober, meet academic requirements and interact with peers and family during after-school and weekend hours. The peer

recovery coach, a young adult in long-term recovery, could assist the special education teacher, provide encouragement and support to struggling students to keep them engaged, and oversee alternative peer group social/recreational activities. Recovery track students and staff would work as a community within the school to promote some prevention, wellness and service activities for the entire school to increase understanding and reduce stigma surrounding addiction.

IEPs and 504 Plans

Given the prealence of co-occuring mental health and learning disorders, students returning to school from substance abuse disorder treatment should be evaluated to determine if they need an IEP or 504 plan. Individualized Education Programs (IEPs) and 504 Plans are formalized plans to ensure that children with a disability who are attending an elementary or secondary school receive accommodations that promote their academic success and access to the learning environment. Students with disabilities are protected under Section 504 of the Rehabilitation Act of 1973, as revised in Section 504 in the area of public elementary and secondary education (US Department of Education, 2019). The Americans with Disabilities Act Amendments Act of 2008 (Amendments Act), effective January 1, 2009, amended the Americans with Disabilities Act of 1990 (ADA) and included a conforming amendment to the Rehabilitation Act of 1973 that affects the meaning of disability in Section 504. The Amendments Act broadens the interpretation of disability. Section 504 protects students with disabilities who attend schools receiving Federal financial assistance. To be protected under Section 504, a student must: (1) have a physical or mental impairment that substantially limits one or more major life activities; or (2) have a record of such an impairment; or (3) be regarded as having such an impairment. Section 504 requires that school districts provide a free appropriate public education (FAPE) to qualified students in their jurisdictions who have a physical or mental impairment that substantially limits one or more major life activities. Such an education consists of regular or special education and related aids and services designed to meet the individual educational needs of students with disabilities as adequately as the needs of students without disabilities are met. The related supportive services can include psychological, counseling and medical diagnostic services and transportation.

Section 504 excludes from the definition of a student with a disability, and from Section 504 protection, any student who is *currently* engaging in the illegal use of drugs when a covered entity acts on the basis of such use, and RHS experts we interviewed interpreted this to exclude students in recovery since they so often relapse. There are exceptions for persons in rehabilitation programs who are no longer engaging in the illegal use of drugs. Section 504's definition of a student with a disability does not exclude users of alcohol. However, Section 504 allows schools to take disciplinary action against students with disabilities using drugs or alcohol to the same extent as students without disabilities. Co-occurring mental health and substance abuse disorders are more prevalent than substance use disorders alone (Davidson & White, 2007), so it may be easier to define IEPs or 504 plans under a mental health diagnosis. The majority of youth with substance abuse problems

would qualify as having a mental health disorder. In the previously cited multi-site evaluation of RHS outcomes (Finch et al., 2018), 92% of RHS students had a co-existing mental health disorder.

The determination of whether a student has a physical or mental impairment that substantially limits a major life activity must be made on the basis of an individual inquiry. Often this inquiry is requested by a parent, but it can also be initiated by the school. The federal Office of Civil Rights has interpreted Section 504 to require districts to obtain parental permission for initial evaluations. However, if a district suspects a student needs special instruction or related services and parental consent is withheld, the IDEA and Section 504 allow districts to use due process hearing procedures to seek to override the parents' denial of consent for an initial evaluation.

There are two formal plans that can be implemented as a result of the evaluation: an Individualized Education Program (IEP) or a 504 Plan. The two plans differ in whether special services are required and the degree of review and monitoring of student's progress and needs (North Shore Pediatric Therapy, 2019). An IEP is for children who qualify for special education services. To qualify, a child must have a documented learning disability, developmental delay, speech impairment or significant behavioral disturbance. Special education is education that offers an individualized learning format. In contrast, a 504 Plan does not include special education services. Instead, a 504 Plan involves classroom accommodations, such as a reduced course load, less homework and environmental supports. An IEP requires a more extensive evaluation process as well as a multi-person team meeting to construct the plan. A 504 Plan is less formal and may involve a meeting with just the parents and teacher(s). Either type of plan should be documented and recorded. An IEP outlines specific, measurable goals for each child, and these are monitored to ensure appropriate gains. A 504 Plan is not required to contain explicit goals. An IEP requires more regularly occurring reviews of progress, approximately every 3 months, whereas a 504 Plan is usually reviewed at the beginning of each school year.

IEP plans are more expensive for schools because they require additional school resources to construct and execute. In Delaware, the team that designs an IEP plan must include: 1) the student's parent(s) or guardian(s), 2) the student if the student is of transition age, 3) at least one of the child's general education teachers, 4) at least one special education teacher, 5) a specialist who can interpret evaluation results, 6) a Career and Technical education teacher or coordinator if the student is participating in a Career-Tech Ed program, and 7) a district representative with authority over special education services (Delaware Department of Education, 2019). A formalized IEP plan developed by this team must include:

- A thorough analysis of how the student is presently performing in school
- The student's educational goals
- A list of services the student will receive, including how often and for how long
- Transition services for students of transition age
- Any accommodations, supports, and services needed for the child to be successful in the general education curriculum

- Whether the child will participate in the state wide assessment with/without accommodations
- The extent to which an eligible school aged child will be included in the general education environments

Under federal law schools are required to provide special education and related services to a student *at no cost*. However, schools may ask parents or guardians to use a child's or a family's public benefits or insurance for reimbursement of services. If a school makes this request, the school must provide, in writing to a parent or guardian, information about a student's rights and protections under the Individuals with Disabilities Education Act (IDEA). This authorization is voluntary. If a parent or guardian agrees to use a child's or family's public benefits or insurance for reimbursement of services, the parent or guardian must provide their consent in writing.

In addition to being expensive, IEPs for high school age youth are subject to disruption when students reach age 18. The law allows a Transfer of Rights upon an individual reaching the age of majority to assure that children with disabilities who have reached age 18 have an identified decision-maker. This is potentially contentious in cases where a youth with an IEP reaches age 18 and disagrees with a parent or guardian on how best to exercise their educational rights.

Students with an IEP or 504 plan are protected from school expulsion for conduct caused by the disability. They are entitled to a manifestation hearing within ten days of a school suspension to determine whether the behavior for which they are being disciplined is a manifestation of their disability. If the behavior is a manifestation of the disability, the child is entitled to continued public education.

In the 2017-18 academic year, 23,196 3-21 year old students in Delaware were served under the Individuals with Disabilities Act (IDEA), Part B. This represented 17% of all public school students in the state, slightly higher than the U.S. percentage of 14%. The number of children served under IDEA in Delaware grew faster than the national rate from 2000 to 2018 - a 38% increase in Delaware compared to an 11% increase in the U.S. (NCES 2018). Although Delaware Department of Education statistics on students served under IDEA do not suggest that youth are currently receiving special services under a substance use disorder diagnosis, federal guidelines allow for services under this designation in limited circumstances. Moreover, epidemiological data on youth with substance use disorders indicate that the majority have co-occurring learning disabilities and/or mental health issues such as anxiety, depression and PTSD (Davidson and White, 2007), and so would qualify for IEPs or 504 plans for these co-occurring conditions.

Although a majority of youth in recovery from a substance use disorder would qualify for services and protections under IDEA, educational officials we spoke to were concerned about the increased resources that would be necessary to provide additional IEPs and 504 plans for these students. Several parents informed us that school administrators actively discouraged them from pursuing IEPs for their children with the rationale that an IEP would stigmatize the child.

Recovery Coaches

Recovery coaching is a type of Peer-Based Recovery Support Services. Recovery coaches may be either self-trained or certified by accrediting agencies, and typically are, themselves, maintaining long-term recovery from substance use disorders. They do not offer primary clinical treatment, but do support persons in outpatient substance use treatment or coming home from treatment to avoid relapse, build community support for recovery, or work on life goals such as relationships, work, or education. Recovery coaches help clients focus on specific actions to improve their present life and achieve goals (White, 2010).

A recent Harvard Medical School study published in Frontiers in Psychology found that recovery coaches with lived experience contributed to "reduced substance use and substance use disorder relapse rates, improved relationships with treatment providers and social supports, increased treatment retention and greater treatment satisfaction." (Eddie et al., 2019) The authors cautioned, however, that these findings, "should be viewed in light of many null findings to date, as well as significant methodological limitations of the existing literature, including inability to distinguish the effects of peer recovery support from other recovery support activities, heterogeneous populations, inconsistency in the definitions of peer workers and recovery coaches, and lack of any, or appropriate comparison groups. In fact, their review could find only a handful of randomized control trials, and none of the evaluations included high school aged youth in recovery.

Stand-alone RHSs are increasingly employing young adult recovery coaches to serve as role models, connect students to counseling and other resources, and to organize and supervisee alternative peer groups. It would be possible to integrate recovery coaches into a regular school-based recovery support community. Certified recovery coaches would be less expensive than teachers or school counselors, but could serve important functions such as texting or calling to encourage daily school attendance, facilitating morning check-ins, making referrals to school counselors when students face critical issues, accompanying students to classes, and planning and chaperoning sober social activities.

Recovery Community at Delaware Technical Community College

Collegiate Recovery Programs (CRPs) are increasing in colleges and universities as a model for peer-driven recovery support. There are at least three times as many CRPs in the country than RHSs. They offer obvious advantages in organization: virtually all their clients are over 18 and emancipated; they are mostly living at college and do not have transportation issues; they have the opportunity to often have a designated dorm facility so that it can operate in some ways as a quasi-residential program; and they are older and their addiction had not been so severe to preclude them getting into college. These programs provide meeting space and some professional facilitation for student peer support groups. The majority of participants in collegiate recovery communities are in recovery from alcohol or drug use disorders, but the groups can also include students dealing with other addictive behaviors such as gambling or eating disorders. In addition to holding support group meetings each week, CRPs organize alcohol and drug-free social

opportunities such as sober tailgates and yoga classes. The college recovery community can engage in outreach activities to inform the broader college community about substance abuse, addiction and the recovery process, and CRC staff can advocate for recovering students in interactions with faculty and administrators. While most CRC activities only include students actively engaged in a recovery program, some activities are open to students who think they may need to address a substance use issue ("sober curious") and to "allies" who have a professional interest in addiction treatment or who support loved ones in recovery.

No systematic research has examined CRPs, but a number of colleges that offer these recovery communities report low relapse rates and above average academic achievement. Although the number of CRPs nationwide is growing, there is a noticeable lack of rigorous evaluation research on the model, its students and their outcomes (Laudet et al., 2014). Laudet and colleagues (2016) surveyed 486 students in 29 CRPs throughout the United States. The students had been abstinent from alcohol and other drugs an average of three years. One third of the sample stated they would not be in college were it not for a peer-based, collegiate recovery program. Their main reasons for joining collegiate recovery programs were the need for same age peer recovery support, and wanting to maintain their sobriety in the high-risk college environment.

We talked to leaders at two CRPs. The first Ms. Sarah Nerad was the Director of the CRP at Ohio State, which has a thriving CRP community. She has also been working for three years through OSU and the state of Ohio to establish a RHS in Columbus. This program is just opening this fall after many bureaucratic and regulatory roadblocks, a lesson in itself she told us of the difference between CRPs and RHSs. The University of Delaware's CRC is coordinated by Jessica Estok, the assistant director of substance use recovery services in the UD Office of Student Wellness and Health Promotion. The story of UDs CRC is reported in Ruth (2019). In our interview with Ms. Estok and Nancy Chase, Director of Student Wellness & Health Promotion they expressed strong agreement that there is a need for recovery support communities for high school age youth in Delaware, and they described elements of the CRC that could be incorporated into a RHS or a recovery support program in a general high school. These elements include regular support group meetings, check-ins to identify relapse or risk of relapse, alternative peer groups to provide substance-free social and recreational opportunities, and outreach activities focused on prevention, advocacy and wellness. Estok and Nutting stated that many of UD's CRC participants are nontraditional students who are older, live off-campus, and have experienced gaps and disruptions in their education due to their substance use or other life challenges. Delaware Technical Community College has many similar students, but does not currently have a CRP.

There are several advantages of a CRP at Delaware Tech either as an alternative to a Recovery High School or in addition to a RHS. A CRP at Delaware Tech could draw on a much larger population of potential students with demonstrated need. Developmentally, youth are much more likely to experience substance use disorders in late adolescence and emerging adulthood than in early or mid-adolescence (SAMSHSA 2018). In the 2017 National Survey on Drug Use and Health (NSDUH), 4% of youth age 12-17 and 15% of transitional age 18-25 respondents met criteria for a Substance Use Disorder. The NSDUH reported higher numbers of older teens/young adults than

younger adolescents receiving treatment for substance use disorders nationally, as is also the case in the Delaware Medicaid data (see Table 7).

Despite the fact that there are far more transitional aged young adults with substance use disorder and many of them have not finished high school, the RHS advocates we spoke to— both parents and professionals— expressed little enthusiasm for including youth aged 19 or 20 in a RHS. While they grudgingly allowed that a few special needs youth that age could be accepted at a RHS, they stated that the developmental differences between older youth and younger teens are probably too great and would place the younger teens at risk. It should be noted that the Massachusetts RHSs do enroll youth up to age 21.

Delaware Tech could meet the educational needs of a broad range of students. It offers high school completion courses, training in skilled trades and vocations at the certification or associate degree level, and classes in core subjects with articulation agreements that allow students to transfer into four year degree programs. Since stable employment is one of the strongest predictors of sustained recovery for adolescents and young adults leaving treatment, a CRP at Del Tech would be well-suited to guiding students on a path to occupational success.

A CRP at Delaware Tech could also have some practical and funding advantages over a Recovery High School. It would not require finding or building a site. The Stanton campus is on a public bus route, so transportation would not be problematic for New Castle County students, at least. A community college setting would not be subject to all of the mandated staffing and reporting requirements that make it difficult to create and operate a stand-alone recovery high school with limited staff. Finally, a variety of funding mechanisms are already in place to cover tuition of many students who would attend Delaware Technical Community College including scholarships, Pell grants, government and private student loans and Delaware SEED grants.

Although a Collegiate Recovery Community at Delaware Tech may potentially serve the greatest number of young adults in recovery and have logistical and financial advantages compared to a Recovery High School, it would be developmentally inappropriate for younger adolescents to socialize with older adolescents and young adults in a college setting without close adult supervision. Thus, directing resources to a collegiate recovery community at Delaware Tech would be a trade-off between serving a greater number of late teens and young adults in need of recovery supports at the expense of the much smaller number of younger adolescents in recovery.

Conclusions

As seen in section 1 of the Report, the review of epidemiological data and interviews with parents and treatment providers reveal that there are significant numbers of high school age youth using drugs in such a manner to suggest substance abuse disorder. Moreover, the Medicaid data taken in conjunction with treatment data from DPBHS and DSAMH point to more youth and young adults getting treatment for substance abuse than had previously been believed. Even with conservative estimates, it seems that there at least 800 students in Delaware high schools meeting criteria for dependence on alcohol, marijuana, or another drug. Even accounting for the fact that there is likely considerable overlap between the school survey, and the treatment data, there are about 500 high school age students (15-17) who have received treatment services for some substance abuse issue in the past year. And if programming is being considered for young adults, the estimate for those receiving treatment 18-20 is about 700, and for those 21-24 it is about 1500.

Both these numbers and the personal accounts from clients and families indicate a need for recovery support services for Delaware adolescents and young adults with substance use disorders who are returning from residential treatment facilities or who receive community-based treatment for SUD. These youth may have experienced educational disruptions and setbacks due to their substance abuse and co-exiting mental health and learning disorders. Often they feel stigmatized and unwelcome in regular public high schools, and they or their family fear that rejoining their former peer culture will lead to relapse. The Recovery High School Movement has developed to address these problems in other communities throughout the US, and the Delaware advocacy group *atTAcK addiction* has called for a recovery high school in Delaware.

A careful review of the history and circumstances of recovery high schools in other states, however, reveals they are not a panacea. Recovery high schools are very expensive, to operate, provide a watered down academic curriculum, struggle to maintain viable enrollment levels, and demonstrate very slight evidence that they lead to reduced substance abuse. For these reasons, it may be a better for Delaware to explore other options or blended options for providing recovery support and meeting the educational needs of youth with substance abuse disorders. These alternatives include: 1) integrating a recovery support track in existing schools; 2) expanding use of IEPs and 504 plans (while hiring more psychologists, teachers, and support staff to design and implement individual plans); 3) hiring recovery coaches to work with students as they return to school; and 4) developing a collegiate recovery community at Delaware Technical Community College.

If Delaware does proceed to develop a Recovery High School, it must dedicate sufficient financial and political support to sustain the endeavor so that RHS administrators do not constantly need to lobby the legislature and seek charitable support to stay afloat. Transportation must be included too if a RHS (singular or plural) is to serve a statewide population. A publicly funded RHS will require a clear recovery model with use of appropriate evidence-based components. A RHS will need to recognize the reality of relapse and the threat it poses to a small RHS community.

Experience elsewhere demonstrates that the RHS environment is not a perfect safe haven of sober peers. Continued substance use is common among RHS students, and a RHS in Delaware will require a plan to deal with continual cases of relapse to drug and/or alcohol use by some students.

Finally, Delaware lawmakers and administrators need to confront the acceptance and availability of marijuana in relation to adolescent substance abuse disorder and recovery. Recovery High Schools have typically served students whose primary substance of abuse is marijuana, and that is the area where they have had their only documented success. To be identified for SUD and services, these students have already experienced problems in school, relationships, or with the law as a result of this use, and they are at risk of developing addiction to other illegal drugs as they enter adulthood. This is likely a major route to opioid addiction. What message does a state with easily available medical marijuana and many advocates for legalized recreational marijuana use send to RHS candidates? Normalization of marijuana use has contributed to the decline even demise of adolescent treatment facilities and reduced RHS enrollments nationwide. There may be reasons for a RHS, but it will not be as simple as, 'If we build it, they will come."

Those who have been involved in substance abuse treatment for many years will be familiar with the work by Martinson and colleagues in the 1970s (Martinson, 1974; Lipton, Martinson, Wilks, 1975). His 1974 article, *What Works* concerning the shortcomings of existing prisoner rehabilitation programs, led many in the research field and particularly program administrators to conclude that "nothing works," creating what became known as the "*nothing works*" doctrine, which set back the provision of treatment service in both corrections and the community for 15 years. From involvement in treatment studies for the last 30 years, we do know that "treatment works," and what we have learned though is it is not "nothing works," but it should be "no one thing works." Almost all the state and community parties involved recognize that there are not enough treatment services available, and are seeking more services and better access to services for those in need. The consensus is that there is a need for residential youth treatment, more adolescent psychiatrists and psychologists, and more accessible outpatient programs and services statewide utilizing a combination of Medicated assisted treatment, cognitive behavioral therapies, and individual and group counseling.

A recovery high school could be a piece of the puzzle needed for a continuum of treatment services, but only a piece. It is expensive per student and should be reserved for a small group of high need, high risk clients, much as is done for those with severe disabilities or chronic needs. It should not be a "demonstration" program as some community advocates would like. In that case, if it is successful for targeted clients, many will want it replicated in other sites in the state, with less assessment of client needs, more inclusion of clients not needing the services of an intensive program with dual educational and treatment needs, less staffing and support per client, and the likely diversion of scarce resources from supporting other treatment alternatives and needed pieces of a coordinated continuum of services.

The state has a current window of opportunity to act when there is a confluence of a better state budget and the presence of new federal funding support from SAMHSA, the CDC, and CMMS to support putting in place:

1. Better assessments of student, youth and young adult needs including existing instruments that can help identify better modalities of treatment and services needed for each individual;
2. New education programs to tell youth and young adults about drugs and where they can go for treatment and new education programs 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 who work with youth, perhaps on the model of the DSCYF behavioral health consultants; 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;
5. Using some of the suggestions in section 4 of the Report above to 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.

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APPENDIX A1

Codes for Substance Abuse and Related Procedures Examined

Substance Use Disorder ICD-10 Codes
Department of Health and Mental Hygiene

(2) For dates of service on or after October 1, 2015:

F1010	Alcohol abuse, uncomplicated
F10120	Alcohol abuse with intoxication, uncomplicated
F10121	Alcohol abuse with intoxication delirium
F10129	Alcohol abuse with intoxication, unspecified
F1014	Alcohol abuse with alcohol-induced mood disorder
F10150	Alcohol abuse with alcohol-induce psychotic disorder with delusions
F10151	Alcohol abuse with alcohol-induce psychotic disorder with hallucinations
F10159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10180	Alcohol abuse with alcohol-induced anxiety disorder
F10181	Alcohol abuse with alcohol-induced sexual dysfunction
F10182	Alcohol abuse with alcohol-induced sleep disorder
F10188	Alcohol abuse with other alcohol-induced disorder
F1019	Alcohol abuse with unspecified alcohol-induced disorder
F1020	Alcohol dependence, uncomplicated
F1021	Alcohol dependence, in remission
F10220	Alcohol dependence with intoxication, uncomplicated
F10221	Alcohol dependence with intoxication delirium
F10229	Alcohol dependence with intoxication, unspecified
F10230	Alcohol dependence with withdrawal, uncomplicated
F10231	Alcohol dependence with withdrawal delirium
F10232	Alcohol dependence with withdrawal with perceptual disturbance
F10239	Alcohol dependence with withdrawal, unspecified
F1024	Alcohol dependence with alcohol-induced mood disorder
F10250	Alcohol dependence with alcohol-induce psychotic disorder with delusions
F10251	Alcohol dependence with alcohol-induce psychotic disorder with hallucinations
F10259	Alcohol dependence with alcohol-induce psychotic disorder, unspecified

F10280	Alcohol dependence with alcohol-induced anxiety disorder
F10281	Alcohol dependence with alcohol-induced sexual dysfunction
F10282	Alcohol dependence with alcohol-induced sleep disorder
F10288	Alcohol dependence with other alcohol-induced disorder
F1029	Alcohol dependence with unspecified alcohol-induced disorder
F10920	Alcohol use, unspecified with intoxication, uncomplicated
F10921	Alcohol use, unspecified with intoxication delirium
F10929	Alcohol use, unspecified with intoxication, unspecified
F1094	Alcohol use, unspecified with alcohol-induced mood disorder
F10950	Alcohol use, unspecified with alcohol-induce psychotic disorder with delusions
F10951	Alcohol use, unspecified with alcohol-induce psychotic disorder with hallucinations
F10959	Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
F10980	Alcohol use, unspecified with alcohol-induced anxiety disorder
F10981	Alcohol use, unspecified with alcohol-induced sexual dysfunction
F10982	Alcohol use, unspecified with alcohol-induced sleep disorder
F10988	Alcohol use, unspecified with other alcohol-induced disorder
F1099	Alcohol use, unspecified with unspecified alcohol-induced disorder
F1110	Opioid abuse, uncomplicated
F11120	Opioid abuse with intoxication, uncomplicated
F11121	Opioid abuse with intoxication delirium
F11122	Opioid abuse with intoxication with perceptual disturbance
F11129	Opioid abuse with intoxication, unspecified
F1114	Opioid abuse with opioid-induced mood disorder
F11150	Opioid abuse with opioid-induced psychotic disorder with delusions
F11151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
F11159	Opioid abuse with opioid-induced psychotic disorder, unspecified
F11181	Opioid abuse with opioid-induced sexual dysfunction
F11182	Opioid abuse with opioid-induced sleep disorder
F11188	Opioid abuse with other opioid-induced disorder
F1119	Opioid abuse with unspecified opioid-induced disorder

F1120	Opioid dependence, uncomplicated
F1121	Opioid dependence, in remission
F11220	Opioid dependence with intoxication, uncomplicated
F11221	Opioid dependence with intoxication delirium
F11222	Opioid dependence with intoxication with perceptual disturbance
F11229	Opioid dependence with intoxication, unspecified
F1123	Opioid dependence with withdrawal
F1124	Opioid dependence with opioid-induced mood disorder
F11250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11281	Opioid dependence with opioid-induced sexual dysfunction
F11282	Opioid dependence with opioid-induced sleep disorder
F11288	Opioid dependence with other opioid-induced disorder
F1129	Opioid dependence with unspecified opioid-induced disorder
F1190	Opioid use, unspecified, uncomplicated
F11920	Opioid use, unspecified with intoxication, uncomplicated
F11921	Opioid use, unspecified with intoxication delirium
F11922	Opioid use, unspecified with intoxication with perceptual disturbance
F11929	Opioid use, unspecified with intoxication, unspecified
F1193	Opioid use, unspecified with withdrawal
F1194	Opioid use, unspecified with opioid-induced mood disorder
F11950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions
F11951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
F11959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
F11981	Opioid use, unspecified with opioid-induced sexual dysfunction
F11982	Opioid use, unspecified with opioid-induced sleep disorder
F11988	Opioid use, unspecified with other opioid-induced disorder
F1199	Opioid use, unspecified with unspecified opioid-induced disorder
F1210	Cannabis abuse, uncomplicated

F12120	Cannabis abuse with intoxication, uncomplicated
F12121	Cannabis abuse with intoxication delirium
F12122	Cannabis abuse with intoxication with perceptual disturbance
F12129	Cannabis abuse with intoxication, unspecified
F12150	Cannabis abuse with psychotic disorder with delusions
F12151	Cannabis abuse with psychotic disorder with hallucinations
F12159	Cannabis abuse with psychotic disorder, unspecified
F12180	Cannabis abuse with cannabis-induced anxiety disorder
F12188	Cannabis abuse with other cannabis-induced disorder
F1219	Cannabis abuse with unspecified cannabis-induced disorder
F1220	Cannabis dependence, uncomplicated
F1221	Cannabis dependence, in remission
F12220	Cannabis dependence with intoxication, uncomplicated
F12221	Cannabis dependence with intoxication delirium
F12222	Cannabis dependence with intoxication with perceptual disturbance
F12229	Cannabis dependence with intoxication, unspecified
F12250	Cannabis dependence with psychotic disorder with delusions
F12251	Cannabis dependence with psychotic disorder with hallucinations
F12259	Cannabis dependence with psychotic disorder, unspecified
F12280	Cannabis dependence with cannabis-induced anxiety disorder
F12288	Cannabis dependence with other cannabis-induced disorder
F1229	Cannabis dependence with unspecified cannabis-induced disorder
F1290	Cannabis use, unspecified, uncomplicated
F12920	Cannabis use, unspecified with intoxication, uncomplicated
F12921	Cannabis use, unspecified with intoxication delirium
F12922	Cannabis use, unspecified with intoxication with perceptual disturbance
F12929	Cannabis use, unspecified with intoxication, unspecified
F12950	Cannabis use, unspecified with psychotic disorder with delusions
F12951	Cannabis use, unspecified with psychotic disorder with hallucinations
F12959	Cannabis use, unspecified with psychotic disorder, unspecified
F12980	Cannabis use, unspecified with anxiety disorder

F12988	Cannabis use, unspecified with other cannabis-induced disorder
F1299	Cannabis use, unspecified with unspecified cannabis-induced disorder
F1310	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F13120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F13121	Sedative, hypnotic or anxiolytic abuse with intoxication delirium
F13129	Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
F1314	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder
F13150	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13151	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolyti-induced psychotic disorder, unspecified
F13180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13181	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13182	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disorder
F13188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder
F1319	Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder
F1320	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F1321	Sedative, hypnotic or anxiolytic dependence, in remission
F13220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium
F13229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified
F13230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
F13232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance

F13239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
F1324	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder
F13250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13281	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13282	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder
F13288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder
F1329	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
F1390	Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
F13920	Sedative, hypnotic, or anxiolytic use, unspecified with intoxication, uncomplicated
F13921	Sedative, hypnotic, or anxiolytic use, unspecified with intoxication delirium
F13929	Sedative, hypnotic, or anxiolytic use, unspecified with intoxication, unspecified
F13930	Sedative, hypnotic, or anxiolytic use, unspecified with withdrawal, uncomplicated
F13931	Sedative, hypnotic, or anxiolytic use, unspecified with withdrawal delirium
F13932	Sedative, hypnotic, or anxiolytic use, unspecified with withdrawal with perceptual disturbances
F13939	Sedative, hypnotic, or anxiolytic use, unspecified with withdrawal, unspecified
F1394	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic, or anxiolytic-induced mood disorder
F13950	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic, or anxiolytic-induced psychotic disorder with delusions

F13951	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic, or anxiolytic-induced psychotic disorder with hallucinations
F13959	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic, or anxiolytic-induced psychotic disorder with, unspecified
F13980	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic, or anxiolytic-induced anxiety disorder
F13981	Sedative, hypnotic, or anxiolytic use, unspecified with sedative, hypnotic, or anxiolytic-induced sexual dysfunction
F13982	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic, or anxiolytic-induced sleep disorder
F13988	Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic, or anxiolytic-induced disorder
F1399	Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic, or anxiolytic-induced disorder
F1410	Cocaine abuse, uncomplicated
F14120	Cocaine abuse with intoxication, uncomplicated
F14121	Cocaine abuse with intoxication with delirium
F14122	Cocaine abuse with intoxication with perceptual disturbance
F14129	Cocaine abuse with intoxication, unspecified
F1414	Cocaine abuse with cocaine-induced mood disorder
F14150	Cocaine abuse with cocaine-induced psychotic disorder with delusions
F14151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
F14159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified
F14180	Cocaine abuse with cocaine-induced anxiety disorder
F14181	Cocaine abuse with cocaine-induced sexual dysfunction
F14182	Cocaine abuse with cocaine-induced sleep disorder
F14188	Cocaine abuse with other cocaine-induced disorder
F1419	Cocaine abuse with unspecified cocaine-induced disorder
F1420	Cocaine dependence, uncomplicated
F1421	Cocaine dependence, in remission
F14220	Cocaine dependence with intoxication, uncomplicated
F14221	Cocaine dependence with intoxication delirium
F14222	Cocaine dependence with intoxication with perceptual disturbance

F14229	Cocaine dependence with intoxication, unspecified
F1423	Cocaine dependence with withdrawal
F1424	Cocaine dependence with cocaine-induced mood disorder
F14250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14280	Cocaine dependence with cocaine-induced anxiety disorder
F14281	Cocaine dependence with cocaine-induced sexual dysfunction
F14282	Cocaine dependence with cocaine-induced sleep disorder
F14288	Cocaine dependence with other cocaine-induced disorder
F1429	Cocaine dependence with unspecified cocaine-induced disorder
F1490	Cocaine use, unspecified, uncomplicated
F14920	Cocaine use, unspecified with intoxication, uncomplicated
F14921	Cocaine use, unspecified with intoxication delirium
F14922	Cocaine use, unspecified with intoxication with perceptual disturbance
F14929	Cocaine use, unspecified with intoxication, unspecified
F1494	Cocaine use, unspecified with cocaine-induced mood disorder
F14950	Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions
F14951	Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations
F14959	Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified
F14980	Cocaine use, unspecified with cocaine-induced anxiety disorder
F14981	Cocaine use, unspecified with cocaine-induced sexual dysfunction
F14982	Cocaine use, unspecified with cocaine-induced sleep disorder
F14988	Cocaine use, unspecified with other cocaine-induced disorder
F1499	Cocaine use, unspecified with unspecified cocaine-induced disorder
F1510	Other stimulant abuse, uncomplicated
F15120	Other stimulant abuse with intoxication, uncomplicated
F15121	Other stimulant abuse with intoxication delirium
F15122	Other stimulant abuse with intoxication with perceptual disturbance

F15129	Other stimulant abuse with intoxication, unspecified
F1514	Other stimulant abuse with stimulant-induced mood disorder
F15150	Other stimulant abuse with stimulant-induced psychotic disorder with delusions
F15151	Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations
F15159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
F15180	Other stimulant abuse with stimulant-induced anxiety disorder
F15181	Other stimulant abuse with stimulant-induced sexual dysfunction
F15182	Other stimulant abuse with stimulant-induced sleep disorder
F15188	Other stimulant abuse with other stimulant-induced disorder
F1519	Other stimulant abuse with unspecified stimulant-induced disorder
F1520	Other stimulant dependence, uncomplicated
F1521	Other stimulant dependence, in remission
F15220	Other stimulant dependence with intoxication, uncomplicated
F15221	Other stimulant dependence with intoxication delirium
F15222	Other stimulant dependence with intoxication with perceptual disturbance
F15229	Other stimulant dependence with intoxication, unspecified
F1523	Other stimulant dependence with withdrawal
F1524	Other stimulant dependence with stimulant-induced mood disorder
F15250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions
F15251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations
F15259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15280	Other stimulant dependence with stimulant-induced anxiety disorder
F15281	Other stimulant dependence with stimulant-induced sexual dysfunction
F15282	Other stimulant dependence with stimulant-induced sleep disorder
F15288	Other stimulant dependence with other stimulant-induced disorder
F1529	Other stimulant dependence with unspecified stimulant-induced disorder
F1590	Other stimulant use, unspecified, uncomplicated
F15920	Other stimulant use, unspecified with intoxication, uncomplicated

F15921	Other stimulant use, unspecified with intoxication delirium
F15922	Other stimulant use, unspecified with intoxication with perceptual disturbance
F15929	Other stimulant use, unspecified with intoxication, unspecified
F1593	Other stimulant use, unspecified with withdrawal
F1594	Other stimulant use, unspecified with stimulant-induced mood disorder
F15950	Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions
F15951	Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations
F15959	Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified
F15980	Other stimulant use, unspecified with stimulant-induced anxiety disorder
F15981	Other stimulant use, unspecified with stimulant-induced sexual dysfunction
F15982	Other stimulant use, unspecified with stimulant-induced sleep disorder
F15988	Other stimulant use, unspecified with other stimulant-induced disorder
F1599	Other stimulant use, unspecified with unspecified stimulant-induced disorder
F1610	Hallucinogen abuse, uncomplicated
F16120	Hallucinogen abuse with intoxication, uncomplicated
F16121	Hallucinogen abuse with intoxication with delirium
F16122	Hallucinogen abuse with intoxication with perceptual disturbance
F16129	Hallucinogen abuse with intoxication, unspecified
F1614	Hallucinogen abuse with hallucinogen-induced mood disorder
F16150	Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions
F16151	Hallucinogen abuse with hallucinogen-induced psychotic disorder with hallucinations
F16159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified
F16180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
F16183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)
F16188	Hallucinogen abuse with other hallucinogen-induced disorder
F1619	Hallucinogen abuse with unspecified hallucinogen-induced disorder
F1620	Hallucinogen dependence, uncomplicated

F1621	Hallucinogen dependence, in remission
F16220	Hallucinogen dependence with intoxication, uncomplicated
F16221	Hallucinogen dependence with intoxication with delirium
F16229	Hallucinogen dependence with intoxication, unspecified
F1624	Hallucinogen dependence with hallucinogen-induced mood disorder
F16250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
F16251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
F16259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
F16288	Hallucinogen dependence with other hallucinogen-induced disorder
F1629	Hallucinogen dependence with unspecified hallucinogen-induced disorder
F1690	Hallucinogen use, unspecified, uncomplicated
F16920	Hallucinogen use, unspecified with intoxication, uncomplicated
F16921	Hallucinogen use, unspecified with intoxication with delirium
F16929	Hallucinogen use, unspecified with intoxication, unspecified
F1694	Hallucinogen use, unspecified with hallucinogen-induced mood disorder
F16950	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with delusions
F16951	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with hallucinations
F16959	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified
F16980	Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder
F16983	Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks)
F16988	Hallucinogen use, unspecified with other hallucinogen-induced disorder
F1699	Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder

F1810	Inhalant abuse, uncomplicated
F18120	Inhalant abuse with intoxication, uncomplicated
F18121	Inhalant abuse with intoxication delirium
F18129	Inhalant abuse with intoxication, unspecified
F1814	Inhalant abuse with inhalant-induced mood disorder
F18150	Inhalant abuse with inhalant-induced psychotic disorder with delusions
F18151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations
F18159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified
F1817	Inhalant abuse with inhalant-induced dementia
F18180	Inhalant abuse with inhalant-induced anxiety disorder

F18188	Inhalant abuse with other inhalant-induced disorder
F1819	Inhalant abuse with unspecified inhalant-induced disorder
F1820	Inhalant dependence, uncomplicated
F1821	Inhalant dependence, in remission
F18220	Inhalant dependence with intoxication, uncomplicated
F18221	Inhalant dependence with intoxication delirium
F18229	Inhalant dependence with intoxication, unspecified
F1824	Inhalant dependence with inhalant-induced mood disorder
F18250	Inhalant dependence with inhalant-induced psychotic disorder with delusions
F18251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
F18259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F1827	Inhalant dependence with inhalant-induced dementia
F18280	Inhalant dependence with inhalant-induced anxiety disorder
F18288	Inhalant dependence with other inhalant-induced disorder
F1829	Inhalant dependence with unspecified inhalant-induced disorder
F1890	Inhalant use, unspecified, uncomplicated
F18920	Inhalant use, unspecified with intoxication, uncomplicated
F18921	Inhalant use, unspecified with intoxication with delirium
F18929	Inhalant use, unspecified with intoxication, unspecified
F1894	Inhalant use, unspecified with inhalant-induced mood disorder
F18950	Inhalant use, unspecified with inhalant-induced psychotic disorder with delusions
F18951	Inhalant use, unspecified with inhalant-induced psychotic disorder with hallucinations
F18959	Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified
F18980	Inhalant use, unspecified with inhalant-induced anxiety disorder
F18988	Inhalant use, unspecified with other inhalant-induced disorder
F1899	Inhalant use, unspecified with unspecified inhalant-induced disorder
F1910	Other psychoactive substance abuse, uncomplicated
F19120	Other psychoactive substance abuse with intoxication, uncomplicated
F19121	Other psychoactive substance abuse with intoxication delirium

F19122	Other psychoactive substance abuse with intoxication with perceptual disturbances
F19129	Other psychoactive substance abuse with intoxication, unspecified
F1914	Other psychoactive substance abuse with psychoactive substance-induced mood disorder
F19150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions
F19151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations
F19159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified
F19180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder
F19181	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction
F19182	Other psychoactive substance abuse with psychoactive substance-induced sleep disorder
F19188	Other psychoactive substance abuse with other psychoactive substance-induced disorder
F1919	Other psychoactive substance abuse with unspecified substance-induced disorder
F1920	Other psychoactive substance dependence, uncomplicated
F1921	Other psychoactive substance dependence, in remission
F19220	Other psychoactive substance dependence with intoxication, uncomplicated
F19221	Other psychoactive substance dependence with intoxication delirium
F19222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19229	Other psychoactive substance dependence with intoxication, unspecified
F19230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19231	Other psychoactive substance dependence with withdrawal delirium
F19232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19239	Other psychoactive substance dependence with withdrawal, unspecified

F1924	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
F19250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
F19251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
F19259	Other psychoactive substance dependence with substance-induced psychotic disorder, unspecified
F19280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
F19282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
F19288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F1929	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder
F1990	Other psychoactive substance use, unspecified, uncomplicated
F19920	Other psychoactive substance use, unspecified with intoxication, uncomplicated
F19921	Other psychoactive substance use, unspecified with intoxication with delirium
F19922	Other psychoactive substance use, unspecified with intoxication with perceptual disturbance
F19929	Other psychoactive substance use, unspecified with intoxication, unspecified
F19930	Other psychoactive substance use, unspecified with withdrawal, uncomplicated
F19931	Other psychoactive substance use, unspecified with withdrawal delirium
F19932	Other psychoactive substance use, unspecified with withdrawal with perceptual disturbance
F19939	Other psychoactive substance use, unspecified with withdrawal, unspecified
F1994	Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder
F19950	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions

F19951	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations
F19959	Other psychoactive substance use, unspecified with psychoactive disorder, unspecified
F19980	Other psychoactive substance use, unspecified with anxiety disorder
F19981	Other psychoactive substance use, unspecified with sexual dysfunction
F19982	Other psychoactive substance use, unspecified with sleep disorder
F19988	Other psychoactive substance use, unspecified with other disorder
F1999	Other psychoactive substance use, unspecified with unspecified disorder
O99310	Alcohol use complicating pregnancy, unspecified trimester
O99311	Alcohol use complicating pregnancy, first trimester
O99312	Alcohol use complicating pregnancy, second trimester
O99313	Alcohol use complicating pregnancy, third trimester
O99314	Alcohol use complicating childbirth
O99315	Alcohol use complicating the puerperium
O99320	Drug use complicating pregnancy, unspecified trimester
O99321	Drug use complicating pregnancy, first trimester
O99322	Drug use complicating pregnancy, second trimester
O99323	Drug use complicating pregnancy, third trimester
O99324	Drug use complicating childbirth
O99325	Drug use complicating the puerperium
R780	Finding of alcohol in blood
R781	Finding of opiate drug in blood
R782	Finding of cocaine in blood
R783	Finding of hallucinogen in blood
R784	Finding of other drugs of addictive potential in blood
R785	Finding of other psychotropic drug in blood

A2.Schools in Association of Recovery Schools	City	ST	# students	Active Y/N	#teacher/ counselor	(www. recoveryschools.org) Notes
Phoenix Academy Charter School	San Rafael	CA	15	Y	1/	Part of the San Rafael school district
Thoreau Continuation High School	Woodland Hills	CA	63	Y	3/2	Active school in upscale community. Not strictly a recovery school. thoreauchs-lausd-ca.schoolloop.com
Amarosa Academy (formerly Santa Rosa Clean & Sober School)	Santa Rosa	CA	--	N	--	As of 2018 both these former "clean and sober" schools "no longer have a recovery-specific program"
Headwaters Academy (formerly South County Clean & Sober School)[4]	Petaluma	CA	--	N	--	
Newport Academy Day School	Costa Mesa	CA		Y		https://www.newportacademy.com/programs/day-schools/
Action Academy	Newhall	CA	--	N	--	Closed 2016 after marijuana legalization (parents would not support drug tests)
Visions Day School	Los Angeles	CA		Y	3/1	https://visionsteen.com/day-school/
YES (Youth Experiencing Success) Clean & Sober School	Santa Cruz	CA		Y		https://www.santacruzcoe.org/student-services/alternative-education-programs/alternative-education-school-sites/yes-youth-experiencing-success/
Landmark Community School	Colorado Springs	CO	--	N	--	Suspended at the end of 2018 school year due to staffing issues. Not yet re-established
River Oak Center	Jacksonville	FL	30	Y	2/4	Urban location, only RHS in state. Web: www.floridarecoveryschools.org
Hope Academy	Indianapolis	IN	25	Y	6/4	https://www.hopeacademyrhs.org
Liberty Preparatory Academy (former Springfield Recovery High School)	Springfield	MA	30	Y	5/2	As with many RHS, school names including recovery and clean and sober are changing to more neutral names http://spslpa.ss18.sharpschool.com
Northshore Recovery High School	Beverly	MA	32	Y	4/3 and a therapy dog	https://www.nsedu.org/schools/northshore-recovery-high-school/

Ostiguy High School	Boston	MA	33	Y	6/3	Takes students 14-21. 8 grads in 2019. http://ostiguyhigh.org
Independence Academy	Brockton	MA	22	Y	4/2	Associated with local community college. https://iarecoveryhs.org/our-team/
Rockdale Recovery High School	Worcester	MA	13	Y	4/1	https://www.cmasscollaborative.org/Recovery_High_School
PEASE Academy (Peers Enjoying A Sober Education)	Minneapolis	MN	21	Y	4/2	https://mtcs.org/pease/ 6 years ago had 65 students
INSIGHT Program	White Bear Lake	MN	15	Y	1/2	https://alc.isd624.org/academics/insightrecoveryschool-clone. INSIGHT is a school within a school
Lakes Recovery School	Detroit Lakes	MN	6	Y	?/2	School within a school, part of public school district. Core content teachers come to classroom 1 hr/day
Central Freedom School	Mankato	MN	7	Y	1/1	Part of school district
Rochester Alternative Learning Center (RALC	Rochester	MN	12	Y	2/1	Part of school district
McKinley ALC Recovery School	Waite Park	MN	6	Y	?/1	https://www.isd742.org/Page/8287 school-within-a-school
Lesniak Experience Strength, & Hope (ESH) Recovery HS	Union	NJ	13	Y	2.5/2.5	http://eshrecoveryschool.org
Daytop NJ Academy	Morristown	NJ	35	Y	3/3	Part of the Daytop system with access to residential and outpatient Daytop programs. Only private RHS https://daytopnj.org/programs/the-academy/
Teen Recovery Solutions Mission Academy H S	Oklahoma City	OK	12	Y	2.5/3	https://www.teenrecoverysolutions.org/program/mission-academy-high-school
Bridge Way School	Philadelphia	PA	13	Y	3/4	https://thebridgewayschool.org
Anchor Learning Academy	Providence	RI		Y	3.5/3	School started a teen center for recovering students in area. https://providencecenter.org/anchor-academy
Ridgecrest Academy	Nashville	TN	--	N	--	The school had 2 students in 2016 and newspaper accounts suggest it is now closed. Its website is no longer active.

Serenity High School	McKinney	TX	10	Y	3/2	Oldest RHS in TX founded in 1999. Now in separate space on McKinney HS campus. Much smaller now. http://serenity.mckinneyisd.net
Archway Academy	Houston	TX	75	Y	6.5/4	Have Recovery Coaches as well as formal counselors http://www.archwayacademy.net
Cates Academy (formerly Three Oaks Academy)	Houston	TX	6	Y	1/1	Flat enrollment for last 5 years
Winfree Academy Courage Program – Grand Prairie	Grand Prairie	TX	16	Y		
Winfree Academy Courage Program – Richardson	Richardson	TX	24	Y		
Winfree Academy Courage Program – North Richland Hills Campus	North Richland Hills	TX	28	Y		
University High School	Austin	TX	21	Y	2/3	http://uhighschool.com
Jose A. Valdez High School	Laredo	TX	60	Y	6/2	Part of regular school district. http://nths.elisd.org
Kent Recovery, Opportunity, Achievement, Desire, Success (ROADS) School	Kent	WA	--	N	--	No longer operating as a RHS, recovering students referred to district alternative school
Interagency Academy	Seattle	WA				Network of small alternative schools in Seattle. https://interagency.seattleschools.org
Horizon High School	Madison	WI	15	Y	4/2	http://www.horizonhs.org
REACH High School	Casper	WY	17	Y	?/2.5	Program within school district. Regular teachers from Roosevelt HS teach one period day. Students can participate in sports and extracurricular at assigned HS

Why does Delaware need a recovery high school?

According to a 2016 United States D.E.A. analysis, the primary drug threats throughout Delaware continue to be heroin and diverted opioid prescriptions. In 2014, **3% of opioid-related deaths took the lives of people 15-24 years old**, and that number is rising. Delaware Health & Social Services' 2018 Budget Hearing indicated that young adult opiate treatment **beds doubled from 16 to 32 during Summer 2016 alone**.

After students exit a treatment facility for substance use disorder, returning to a traditional high school may support past behaviors or encourage dropping out. Continuing care is arguably the most essential component to successful long-term recovery. 47% of all students who return to traditional high schools after leaving treatment resume habitual drug use within one year, and **the first 60 days following treatment hold the greatest risk**. Without a recovery high school available for young Delawareans in recovery, we're failing to support a population of young adults standing at a vulnerable crossroad.

Contact us to learn how you can help

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atTAcK addiction™
Established February 2013

www.atTAcKaddiction.org

What is a recovery high school?

Why does Delaware need one?

Our mission is to raise awareness about the disease of addiction through educating communities, assisting families in their quest for information, and supporting those in recovery. ***atTAcK addiction*** seeks to remove the stigma of addiction by affecting positive change in Delaware.

What is a recovery school?

Since 1987, high schools specifically modeled to support students recovering from substance use disorders have emerged across the US. The goal of a recovery high school is to reduce the factors contributing to relapse in a student's experience by providing services to this specialized population by developing a strong, centralized community and other supportive services. Because it is a high school, it has an additional goal of graduating students who are ready for college or careers.

In 2010 under President Obama, the first National Drug Control Strategy report was published with a statement in ardent support of this approach, calling for "expansion of community-based recovery support programs including recovery schools."

The period following completion of a treatment program, when youth return to their family, peers, and neighborhoods, is proven to be the time of greatest relapse risk. Recovery high schools uniquely service this population by establishing a community commitment to sobriety, re-engaging students with substance use disorders in the educational process, and helping them re-imagine happy and successful futures. Transitioning from treatment to every-day life in the early stages of recovery is an incredible challenge for people of all ages, and our young people need our support to navigate that transition. Recovery schools provide stability and support for students returning to their education, helping avoid a cycle of relapse and treatment. It is our hope that access to these supports will end the cycle for Delaware students.

5 Functions of Recovery High Schools

1. Operate as a state-recognized high school with academic programs designed specifically for students in recovery from substance use disorder
2. Provide academic services, recovery assistance, post-treatment support, and continuing care in addition to the other services provided to all high school students in our state
3. Require that all students be sober and working a recovery program outlined by the student, medical professionals, and the school while enrolled
4. Offer academic courses for which students receive credit toward a high school diploma and provide services that assist the student in making a transition to college, career, or another high school
5. Adhere to an established plan to handle therapeutic needs of students and the special needs of those in crisis