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Rationale for Including Recovery as Part of the Educational Agenda

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Summary
Below please provide a brief summary of this resource. If an abstract is available, feel free to copy and paste it here.

This resource is an overview of a volume describing the systems of support within the educational community available to young people in recovery. This resource is not the volume itself, but is an overview that introduces the field of adolescent recovery in the educational community, and lays out the structure of the volume. The volume described is designed to be a synthesis of research and practical design methods for implementing programs supportive of recovery in the educational community.

The volume described is intended to tell the story of people helping themselves, developing programs one step at a time, and trying to "keep it simple." The structure for the volume emerges from the classic format for a "lead" in Alcoholics Anonymous, where the speaker talks about "How it was, how I got here, and what it is like now."

The volume described contains twenty chapters by various authors and leaders in the field of adolescent recovery.

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Rationale for Including Recovery as Part of the Educational Agenda

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Rationale for Including Recovery as Part of the Educational Agenda

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In recent years, adolescent and young adult alcohol and drug use has garnered attention from scholars, legislators, parents, and the media. There is disagreement as to whether substance abuse by this population is in decline or as problematic as ever. The side one takes depends upon which data is used and how that data are interpreted. While the extent of the issue for adolescents and young adults is in dispute, the existence of problem drug use among this group is not. In 2005, 2.1 million youths in the United States aged 12 to 17 (8.3% of this population) met the DSM-IV (American Psychiatric Association, 1994) diagnostic criteria for a substance use disorder—that is, dependence on or abuse of alcohol or illicit drugs (Substance Abuse and Mental Health Services Administration, 2006). More than 918,000 U.S. college students can be diagnosed as alcohol dependent, and on an average campus of 30,000 students, nearly 9,500 meet the criteria for substance use disorders (Harris, 2006).

For good reason, there has been extensive literature devoted to preventing young people from developing an alcohol or drug problem, early identification and assessment of those who are developing a problem, and evidenced-based interventions and treatment for those who are exhibiting problem use or dependence. The case can be made that investment in prevention and early identification programs can benefit everybody who listens to the message. Some may choose never to drink alcohol or use drugs, others will learn to do so responsibly, and for those who do

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not use substances responsibly, either harm can be reduced or treatment administered.

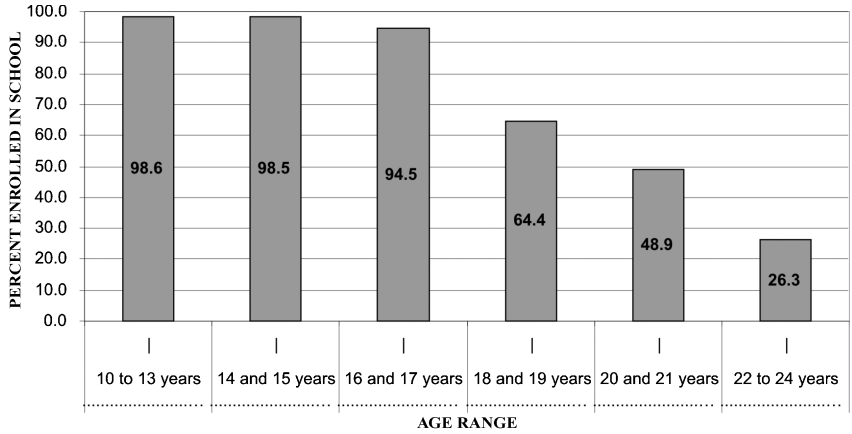
Far less attention has been paid, however, to those students who have finished treatment. Studies on posttreatment continuing care are growing, but they still are outnumbered by prevention and treatment studies. Programs for students in recovery exist primarily as "aftercare" programs in treatment centers, and these vary in client commitment. Indeed, with less than only about 1% of adolescents and young adults receiving treatment annually (Substance Abuse and Mental Health Services Administration, 2006), it can be difficult to channel funds toward programs that support their recovery.

The data that has been collected on adolescents and young adults after receiving treatment portrays a grim picture. Treatment outcome studies have found first use posttreatment to be 42% in the first 30 days (Spear & Skala, 1995, Table 6), 64% by 3 months (Brown, Vik, & Creamer, 1989), 70% by 6 months (Brown, Vik, & Creamer, 1989), and 77% within one year (Winters, Stinchfield, Opland, Weller, & Latimer, 2000). By 12 months, 47% return to regular use (Winters, Stinchfield, Opland, Weller, & Latimer, 2000). While some of this can be attributed to the quality of the treatment program, much can be attributed to the environmental factors in place after treatment (Godley, Godley, Dennis, Funk, & Passetti, 2002). Adolescents and young adults develop their identities through peer connection and interaction. Once young people have decided to stop using alcohol or drugs, the people with whom they interact and the support systems available will play a major role in determining their success.

This volume is about those systems of support—specifically, systems of support within educational communities. Obviously schools provide a major, if not the main, system of peer interaction and support for adolescents and young adults. According to the U.S. Department of Education, 57% of the U.S. population aged 3–34 is enrolled in a school, and this does not include trade schools or correspondence programs. At age 14 and 15 (the standard age for starting high school), 98.5% of the population is in school. By age 22 through 24 (when many are finishing college), 25% of the population is still in school (Figure 1).

This means that when a person decides to seek help for a substance use disorder, anywhere from a fourth to nearly all of those people—depending on their age—will be involved with an educational community. And young people between ages 14 and 18 will most likely be in a school community every day, seven hours per day. The education community for boarding

FIGURE 1. Percentage of the Population 10 to 24 Years Old Enrolled in School, 2004



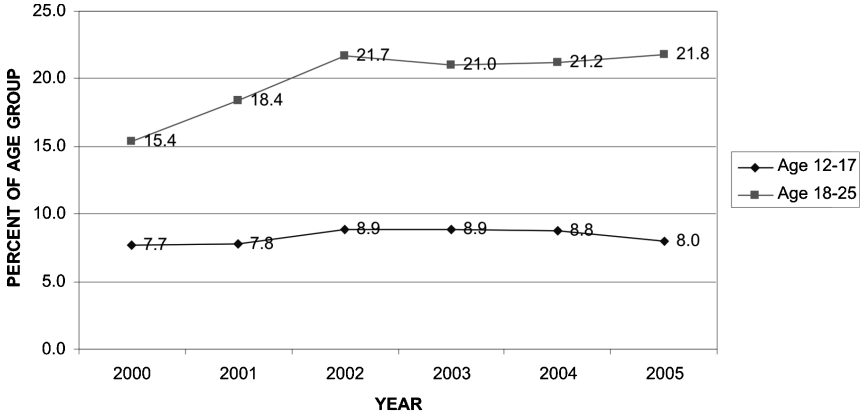
NOTE: Includes enrollment in any type of graded public, parochial, or other private schools. Includes elementary schools, middle schools, high schools, colleges, universities, and professional schools. Attendance may be on either a full-time or part-time basis and during the day or night. Enrollments in "special" schools, such as trade schools, business colleges, or correspondence schools, are not included. (U.S. Department of Education, 2006, Table 6) .

school students and many college students often represents the entire living and social community as well.

Regardless of age or living arrangement, though, education communities provide a powerful source of influence upon adolescents and young adults, and thus there exists both opportunity and risk. The risks have been well documented through substance use and abuse studies and efforts to prevent problem use or reduce the harm of substance "misuse." Efforts to create "social norms" around "responsible" drinking and drug use in order to eliminate "binge" drinking on high school and college campuses have taken root in education communities over the last decade. Though the effectiveness of prevention programs like DARE. (Hallfors & Godette, 2002) and social norms theory (Polonec, Major, & Atwood, 2006) has been disputed, the good news is that the recent reports suggest adolescent substance use and abuse may be in decline (Johnston, O'Malley, Bachman, & Schulenberg, 2007; Substance Abuse and Mental Health Services Administration, 2006). The intense focus on the "teen drug problem" appears to be working.

The number of students ages 12–17 needing and receiving treatment for alcohol or drug use problems or dependence, however, has stayed

FIGURE 2. Substance Abuse or Dependence, by Age

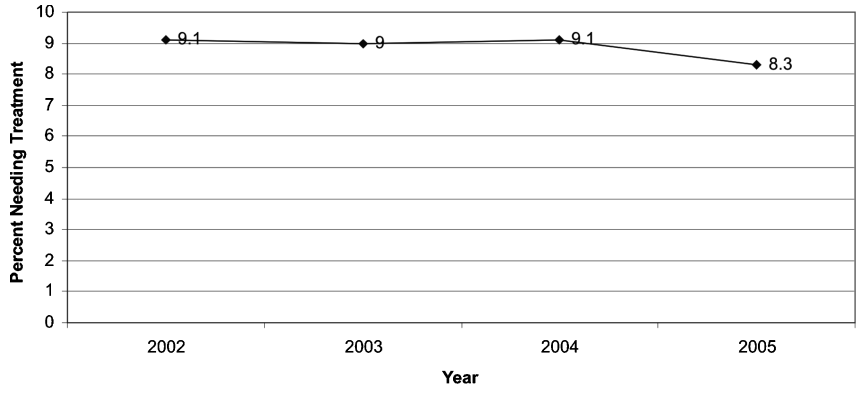


NOTE: Criteria for dependence on or abuse of a substance is based on usage in the past 12 months. Substances include alcohol and illicit drugs, such as marijuana, cocaine, heroin, hallucinogens, and inhalants, and the nonmedical use of prescription-type psychotherapeutic drugs. Classifications are based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV) (American Psychiatric Association, 1994). According to the NSDUH, dependence is considered to be a more severe substance use problem than abuse because it involves the psychological and physiological effects of tolerance and withdrawal. Although individuals may meet the criteria specified for both dependence and abuse, persons meeting the criteria for both are classified as having dependence, but not abuse. Persons defined with abuse do not meet the criteria for dependence (Substance Abuse and Mental Health Services Administration, 2006).

consistent. In 2000, SAMSHA's National Survey on Drug Use and Health (NSDUH)—formerly the National Household Survey on Drug Abuse—began reporting the number of people with a substance use disorder by age group. From 2000–2005, the percentage of people with a substance use disorder rose from 15.4% to 21.8% for ages 18–25 and hovered between 7.7% and 8.9% for ages 12–17 (see Figure 2) (Substance Abuse and Mental Health Services Administration, 2006).

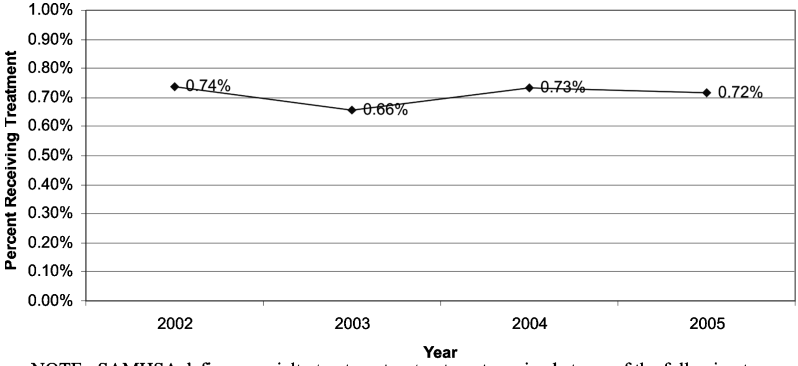
Since 2002, when the NSDUH began reporting the percentage of people needing and receiving treatment for a substance use disorder in a "specialty treatment center," just under 9% of the population aged 12–17 has needed treatment (see Figure 3), and just under 1% has gotten it (see Figure 4) (Substance Abuse and Mental Health Services Administration, 2006). Policymakers often focus on the obvious "treatment gap," which is the difference between those needing and those receiving treatment—a mean of 8% over the four years. Factors such as treatment availability, cost of treatment, and client demographics and culture impact the size of the "gap."

FIGURE 3. Needing Specialty Treatment for Alcohol or Illicit Drug Abuse or Dependence, Ages 12–17



Recovery support programs are concerned with the size of the treatment gap. If people who need treatment—whether it is brief or long-term—cannot get it, they will have no recovery to support. Student assistance programs have existed since the 1970s to identify and assist students at risk

FIGURE 4. Receiving Specialty Treatment for Alcohol or Illicit Drug Abuse or Dependence, Ages 12–17



NOTE: SAMHSA defines specialty treatment as treatment received at any of the following types of facilities: hospitals (inpatient only), drug or alcohol rehabilitation facilities (inpatient or outpatient), or mental health centers. It does not include treatment at an emergency room, private doctor's office, self-help group, prison or jail, or hospital as an outpatient. An individual is defined as needing treatment for an alcohol or drug use problem if he or she met the DSM-IV (American Psychiatric Association, 1994) diagnostic criteria for dependence on or abuse of alcohol or illicit drugs in the past 12 months or if he or she received specialty treatment for alcohol use or illicit drug use in the past 12 months (Substance Abuse and Mental Health Services Administration, 2006)

for substance use problems, and these programs have provided a gateway to treatment as well as aftercare for students. Parents may be oblivious to or contributing to the problem, and parents simply do not see their teenage children for the blocks of time around peers that schools do on a daily basis. Once these young adults go to college, parental contact and involvement usually becomes sporadic and episodic. Thus, school-based identification, intervention, and treatment efforts may be the best chance for some students to access services.

Beyond the treatment gap, however, recovery support programs are keenly aware of the data in Figure 4. Though the percentage of high school students receiving treatment at a specialty treatment center has remained under 1% of that population, the raw number of students age 12–17 reveals a range of 168,000 to 186,000 high school students receiving treatment annually from 2002–2005. And as the treatment gap diminishes, the demand for appropriate and sound posttreatment programs could rise dramatically. While not every young person who uses (or abuses) substances requires treatment, hundreds of thousands do. The school environment they return to after that treatment experience will contribute to integration of the "gains" of treatment—or to the reemergence and/or worsening of pretreatment substance use.

EXISTING RECOVERY SUPPORT LITERATURE

This volume will provide the deepest review yet of the existing literature on the continuum of care for adolescent and young adult substance use disorders. Post-treatment continuing care services have long been seen as an "essential" component of the treatment continuum (Brown & Ashery, 1979; Hawkins & Catalano, 1985; McKay, 2001). With some exceptions, however (Godley, Godley, Dennis, Funk, & Passetti, 2002; Spear & Skala, 1995; Winters, Stinchfield, Opland, Weller, & Latimer, 2000), overall research about posttreatment continuing care for adolescents and young adults has been limited. Even thinner is research conducted on recovery schools, which has been limited to theses and dissertations (Doyle, 1999; Finch, 2003; Rubin, 2002; Teas, 1998), single-site evaluations (Diehl, 2002), and unpublished reports (Moberg, 1999; Moberg & Thaler, 1995).

Professional publications have begun to embrace the concept of recovery support in schools as an emerging field. Recovery historian William White

recently coauthored a history of recovery schools and has also looked closely at collegiate recovery communities in particular (White, 2001; White & Finch, 2006). Other professional pieces have examined first person perspectives and challenges facing the expansion of recovery schools (e.g., Finch, 2004). Hazelden has also published a startup manual for recovery high schools (Finch, 2005).

One area where school recovery support programs have received more broad support is the popular media. Television, newspapers, and Internet sites have featured many "human interest" stories from high schools and colleges since the early 1990s. While these stories may lack the rigor of a refereed journal, they have also shined a light on programs and provided a forum for testimonials. This has allowed recovery programs in high schools and colleges to garner support, and 25 recovery high schools and six collegiate recovery communities opened across the United States from 1999 to 2005 (White & Finch, 2006).

McKay (2001) outlined a series of future directions in research on continuing care, and, by design, this volume addresses one of McKay's key concerns: characterizing types of continuing care services and documenting how widely available they are. McKay also called for identifying the types of continuing care services that are associated with the best outcomes, and many of the articles here address program outcomes. By systemically describing the impact of education communities upon recovery from substance use disorders, this volume aims to establish the place of recovery support practices across schools.

ORGANIZATION OF THE VOLUME

This volume is designed to be a synthesis of research and practical design methods for implementing programs supportive of recovery in the educational community. The introduction sets the stage by combining material that provides a rationale for this synthesis with the relevant systems theory, coupled with participation of "authentic voices" of students who have participated in this kind of programming. The next three sections of the book follow the classic pattern of the recovering addict telling the story of recovery: (1) "How it was," (2) "How I got here," and (3) "How it is now." Each of these sections therefore begins with the transcript of a Twelve Step meeting of the students whose "authentic voices" are included in the introduction.

CONTRIBUTORS

Researchers, students, and professionals each have a voice in this volume. Authors were invited based on experience and expertise not only with substance abuse but also with educational communities. The continuum of care is represented, as is a range of schooling from secondary through higher education. All the professionals have worked directly with students who abuse substances, who are in treatment, or who are in recovery. The researchers have conducted studies of school programs designed to assist students with substance use disorders. The researchers have been (or are still) active professionals in the field. The student authors either attend or have graduated from a recovery high school or collegiate recovery community. As they are the only people invited to contribute to this work who were asked to openly acknowledge their chemical dependency, we will protect their anonymity by using only their first names and not linking them directly to a particular school.

CONCEPTUAL BASE

We have attempted to insure that this volume is not ideologically driven. Recovery-based programs in high schools and colleges have come from the "grass-roots." They have been efforts to address recovery support needs—as understood by staff and students—that were not being handled by existing treatment and "aftercare" programs. The pioneers in this field did not rely on "evidence-based" programming, because in most instances, no evidence yet existed. This volume is a step toward filling the literature void and beginning to understand the foundations of recovery support in educational communities.

There are many pathways to recovery, and this volume does not promote one form over another. It is intended to tell the story of people helping themselves, developing programs one step at a time, and trying to "keep it simple." The structure for this volume emerges from the classic format for a "lead" in Alcoholics Anonymous, where the speaker talks about "How it was, how I got here, and what it is like now." The reason for this is two-fold. First, the Twelve Step philosophy is embedded in many recovery school communities—in large part because it was the predominate modality as these programs were established, and it remains pervasive. Perhaps more important, Twelve Step and other "mutual aid" programs are rooted in the stories of their participants. This format lends itself to a literary work.

After the introductory chapters of Section I, therefore, Section II opens with an overview of the problem of substance use, abuse, and dependence in the adolescent and young adult population—that is, "How it was." Section II concludes with a description of interventions designed to help students move toward recovery from addiction—that is, "How I got here."[1] Sections III and IV describe high school and college programs, respectively, which are designed to support recovering students in the educational community—that is, "Where we are now."

Following this format, data directly from students representing the programs we are describing are included in each part of the work. In the introductory Section I, students respond to central questions regarding their histories of substance abuse, dependence, and recovery. In Section II, we use a transcript of an online Twelve Step meeting in a chat room conducted by the students, where the topic was the First Step describing the loss of control and unmanageability of their disease (how it was). In the Section II part, as we transition from "How we got here" to "Where we are now," we include a transcript from an online student meeting on the Second Step. And in Section IV, we conclude the volume with a transcript from an online student meeting on the Twelfth Step (carrying the message—what it is like to be in recovery in their own educational community).

OVERVIEW OF THE CHAPTERS

Following the introductory chapters of Section I, Section II has four chapters concerning "How it was" and "How we got here." As mentioned above, this section opens with a transcript from an online First Step meeting. Step One of Alcoholics Anonymous says, "We admitted we were powerless over alcohol—that our lives had become unmanageable" (Alcoholics Anonymous, 2001). This is the focus of the first meeting in Chapter 3. Co-editor Jeffrey Roth has annotated the transcript of each online meeting to help readers understand how this particular meeting corresponds with the traditions, flow, and content of a traditional Twelve Step meeting.

Chapter 4 is titled "The Education Community as a Collection of Groups and Organizations." In this chapter, Jeffrey Roth and Seth Harkins frame adolescent substance use and addiction within systems and organizational theory. They explain how we must approach recovery support as a systemic issue, of which recovery high schools and collegiate recovery communities are one part.

Section II follows with a paper by Keith Russell, "Adolescent Substance Use Treatment: Service Delivery, Research on Effectiveness, and Emerging Treatment Alternatives." Chapter 5 addresses the scope of the problem of adolescent substance use, along with existing and emerging models for treating it.

A key pathway to recovery for adolescents can be recovery support groups. Lora Passetti and Bill White's chapter, "Recovery Support Meetings for Youths," thus concludes Section II's focus on "How we got here." In Chapter 6, Passetti and White review the history of youth involvement in meetings, provide a rationale for enhancing participation, summarizes current research, and discuss issues professionals may want to consider when making referrals. The authors consider research showing how the Twelve Step approach can be effective, but also how it is not the most appropriate resource in every case. While the Twelve Step philosophy undergirds most of the existing recovery support programs in educational communities, new and continuing programs must consider how to best incorporate not only Twelve Step principles but also other paths to recovery to assist a more diverse student body.

Sections III and IV are concerned with "Where we are now." Step Two of Alcoholics Anonymous states, "We came to believe that a power greater than ourselves could restore us to sanity" (Alcoholics Anonymous, 2001). Young people battling a substance use problem or dependence usually come to the belief stated in Step Two while also being part of an educational community. As a transition into the final sections of the work, Chapter 7 transcribes and annotates an online Step Two meeting. The chapters that follow describe recovery in the educational community, first high schools and then colleges.

Chapter 8, "Recovery High Schools as Support for Substance Use Disorders" by Andrew Finch and Paul Moberg, provides data from the first-ever national study of recovery high schools. This descriptive study describes services provided, funding to assure institutional viability, outcome goals, characteristics of the students in terms of substance use disorder, treatment history, comorbidity, socioeconomic status and accessibility. An empirically grounded descriptive typology of programs is also presented.

Chapters 9 through 11 provide first-person accounts from professional teachers and counselors who work in and administrate three different recovery high schools in Minnesota. The first recovery high school, Sobriety High, opened in Minnesota in 1987, and about a dozen recovery high schools are currently operating in the state. Angela Wilcox has taught in both of the first two recovery high school organizations, Sobriety High

and PEASE Academy. Her chapter, "TITLE" describes her experience of teaching English in those schools. She also describes her use of "restorative justice," which has spread to many recovery high schools as a way of handling issues that arise with discipline, relapse, dishonesty, and so on.

The first recovery high school to utilize restorative practices was Solace Academy in Chaska, Minnesota. In Chapter 10, "A Secondary School Cooperative: Recovery at Solace Academy, Chaska, Minnesota," Monique Bourgeois explains how this school formed and operates. Solace Academy has a unique institutional basis, operating as a cooperative venture between two counties and seven school districts. In times where collaborations beyond school walls and across community boundaries have become essential for small schools, the story of Solace Academy offers a promising concept for new schools.

Chapter 11, "The Insight Program: A Dream Realized," describes the creation of a "school within a school." The Area Learning Center (ALC) is an alternative school modality established first in Minnesota, serving K-12 students and adults. ALCs offer a broad range of services, including both regular and GED diplomas, as well as child care and remedial programs (Barr & Parrett, 2003). ALCs were authorized by the so-called "second chance law" passed by the Minnesota State Legislature in 1987 (Boyd, Hare, & Nathan, 2002). Any student up to age 21 residing in Minnesota, regardless of his or her "home" district, may attend any ALC, as long as the student meets one of a number of qualifying "at-risk" conditions, including assessment for chemical dependency. The Insight Program was created as a recovery school within the White Bear Lake (Minnesota) ALC, and Bowermaster explains the creation and development of that program.

In recent years, there has been a surge in recovery support services on college campuses as well. Four chapters here focus on collegiate recovery communities. The term "collegiate recovery community" was coined by the Center for the Study of Addiction and Recovery at Texas Tech University, a program begun by Carl Anderson in 1986. In Chapter 12, "Achieving Systems-Based Sustained Recovery: A Comprehensive Model for Collegiate Recovery Communities," the current director, Kitty Harris, and colleagues provide data around the need for and effectiveness of college recovery support programming. The Texas Tech collegiate recovery community has been promoted as a model program by the Substance Abuse and Mental Health Administration (SAMHSA).

Unlike high school recovery support programs, collegiate recovery communities obviously do not enroll full schools of students. For this reason,

the extent of services varies from college to college depending on need and institutional design. Rutgers University opened its Alcohol and other Drug Assistance Program for Students (ADAPS) in 1983. Lisa Laitman is the founder of that program, and in 1986 she opened the first "recovery house" on a college campus. The Rutgers program provides services along the full continuum of care, from early identification and intervention through residential recovery support. Laitman and colleague Linda Lederman explain Rutgers' extensive model in Chapter 13, "The Need for a Continuum of Care: The Rutgers Comprehensive Model."

As mentioned earlier, published research and evaluation works on recovery schools are lacking. In Chapter 14, "Assessment and Outcome of a College Substance Abuse Recovery Program: Augsburg College's StepUP Program," Ken Winters provides one of the first published program evaluations of a collegiate recovery community.

The last of the four college-focused chapters is one of the volume's "authentic voice" pieces. In 1977, Classics professor Bruce Donovan was appointed Associate Dean with Special Responsibilities in the Area of Chemical Dependency at Brown University. He served in that role until 2003, and in the process established the first and oldest recovery support program on a college campus. One year after his retirement, Professor Donovan gave an address at the Association of Recovery Schools' third annual conference at Rutgers University. He reflected upon his career and the experience of breaking ground in the area of collegiate recovery support at a prestigious university. Chapter 15 has been developed from the text of his talk on July 10, 2004.

The volume concludes with a final online student Twelve Step meeting. Step 12 of Alcoholics Anonymous says, "Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs" (Alcoholics Anonymous, 2001). Ongoing support of oneself and others who may be suffering is the crux of this message. Hence, the online Twelve Step meeting in Chapter 16 focuses on how these students have been supported and "carried the message" to others.

CONCLUSION

This work covers a large swath of territory concerning recovery support in educational settings. We address many issues along the continuum of care in an effort to place attention on this topic. Of course, much ground

remains uncovered. Studies comparing recovery school programs to each other and to nonrecovery school communities are needed. The field needs to examine schools within alcohol and drug treatment centers as well as the growing presence of "grass-roots" student recovery support organizations and houses not affiliated with schools. Furthermore, we need to understand the lack of racial and ethnic diversity in specialty treatment programs and recovery school communities. How can schools reach a broader base of students? Should more recovery high schools start providing outpatient treatment services as a precursor to recovery school enrollment? What doors to recovery other than Twelve Step programs are showing promise and wide-spread availability to students? Special needs and barriers to access both deserve more attention. This volume has fired a starting gun we hope will generate discussion, research, and publication in these and other areas relevant to recovery support in educational communities as recovery finally establishes a place on the nation's educational agenda.

NOTE

1. Student Assistance Programs (SAPs), a main source of prevention and intervention in high schools, are not addressed at length in this work. SAPs have existed in the United States since the 1980s, and, while they provide some level of recovery support, many student assistant professionals focus on prevention and early identification/intervention. The scope of SAPs varies from state to state and district to district, and a relevant discussion of these programs deserves its own volume. The National Student Assistance Association (http://www.nsac.info/) can provide more information about the scope and evidence-based practices of SAPs in the United States

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