

**A Needs Assessment of School-Based Supports  
for New Hampshire's Substance Dependent Students**  
**Prepared by: Sharyn J. Zunz, PHD & Kelley Binette, MSW**  
**University of New Hampshire**

**Introduction**

In the decades since schools first began to offer substance-related programs to their students, one of the few agreed upon concepts has been the need for a comprehensive continuum of services from primary prevention aimed at non-users to tertiary prevention to support students in recovery (Doweiko, 2002; Kaminer, 2001; NCASA, 2001; PIRE, 1999). Despite this agreement, the majority of school-based services and funding continues to focus on primary prevention with much of the effort aimed at identifying the most effective way to discourage use of alcohol, tobacco, and other drugs (Brown, 2001; Johnston, O'Malley, & Bachman, 2001, US Dept. of HHS – SAMHSA, 2002). Although a concentration on primary prevention is understandable given that schools are striving to use their limited resources to reach the greatest number of students, such an exclusive focus has resulted in what the National Center on Addiction and Substance Abuse (2001) calls the “Malignant Neglect” of teens who are identified as dependent on drugs and alcohol

In 1994, Title 4 of the Improving America's School\Safe and Drug Free Schools and Communities Act proclaimed the goal of eliminating drugs and alcohol from every U.S. school by the year 2000 (Brown, 2001). Although controversy exists about the exact number of students who continue to abuse substances at any given time (Lewin, 2002), no one claims we are close to reaching this lofty Title 4 goal. For example, the most cited data on student substance use and abuse from the National Household Survey on Drug Abuse, the Monitoring the Future Studies, and the Youth Risk Behavior Survey

(Brown, 2001; Johnston, O'Malley, & Bachman, 2001; Lewin, 2002; NHSDA, 2001; ONDCP, 2001; PLNDP, 2002; US Dept. of HHS – SAMHSA, 2002) finds that within a given month, a quarter (25.7%) of high school seniors use illicit drugs and between 40-41% of seniors (27.5% of 12-17 year olds) consume alcohol with between 19 - 26% of 12-20 year olds engaged in binge drinking (five drinks or more on one occasion).

Additionally, the research indicates that it is common in adolescent chemical dependency to find multiple, co-existing problems. For example, the National Household Survey on Drug Abuse (2001) documents the frequency of multiple addictions with 65.5% of heavy drinking adolescents also using other drugs (compared to 4.2% of teen nondrinkers using drugs). Adolescent substance abuse is also linked to increased risk for suicide, accidental injuries, and hospital emergency room visits by teens (Doweiko, 2002). Liddle (2002) describes the link between adolescent substance abuse and other problems as follows (pg. 4):

We know, for example, that adolescent substance abuse co-occurs with other problems quite frequently. In fact, co-morbidity is the norm in most clinical samples of drug-abusing teenagers. Interpersonal difficulties, family, school, and legal problems are more often the rule than the exception. ... We also know that individual-level factors, including executive cognitive functioning and emotional regulation, such as impulsivity and sensation-seeking interact synergistically with familial and environment circumstances.

Other authors describe the ripple effect of student substance abuse on schools by citing the inability of substance dependent students to learn, their risk for poor attendance and/or dropping out, their involvement in school violence incidents and anti-social behavior, and their potential for sexual experimentation and exploitation (NCASA, 2001; Schydlower & Anglin, 1995). However, despite the fact that 4.6 million 12-17 year olds are at moderate to high risk for the multiplicity of problems caused by substance

dependence, only 36% of our nation's public schools (14% of private schools) offer any direct form of substance-related counseling by qualified staff (NCASA, 2001, 2002). Instead of supports, counseling, or programming, our schools spend \$41 billion a year on expenses such as locker searches, drug testing, disciplinary problems, truancy monitoring, and expulsion hearings (NCASA, 2001).

New Hampshire has not been spared from the teen substance abuse problems cited above. The 2000-2001 TAP Multi-Community Report (UNH-Coop. Ext., 2002) states that 1/3 (34%) of the NH's teens admit to using alcohol once a month or more (over 50% of the state's high school seniors), 14% admit to driving while under the influence, and 40% of high school students admit to binge drinking. TAP reports that 19% of the state's teens admit to smoking marijuana at least monthly with 15% of high school students admitting to using marijuana at least weekly. In addition, 26% of those who were admitted for substance abuse treatment in NH in 1999 were under 20 years old with 61% of this group abusing marijuana, 22% abusing multiple substances (almost always alcohol with another drug) and 17% using heroin (Office of Applied Studies State Treatment Episode Data Set; SAMHSA, [www.samhsa.gov](http://www.samhsa.gov), retrieved 1/10/03).

Thus, given the evidence of our continuing struggle with adolescent substance abuse, and given agreement on the need for a continuum of services for students identified as "substance dependent," those whose functioning is impaired by their regular use of substances, the question of the role (if any) of NH's public schools in providing support to these students becomes central. Therefore, this study was undertaken to provide a snapshot of what selected NH high school personnel see themselves already

doing for their substance dependent students and what they see as needed improvements in services for such students who continue to attend their schools.

### **Methodology**

Questionnaire Construction – A questionnaire was constructed by Dr. Zunz and Ms. Binette (See Sample in Appendix A). The questionnaire included scaled variables as well as places for qualitative responses. The UNH TAP (UNH-Coop Ext, 2002) survey and other previously used instruments were consulted to aid in questionnaire construction. The questionnaire was also reviewed by other UNH Social Work department faculty for input before the final version was printed. The questionnaire, consent letters, and all other project documents were submitted to the University's Institutional Review Board for approval. Approval was received on September 4, 2002.

Sample Selection – A list was developed of all the public high schools in the state of New Hampshire using information provided by the state's website ([www.ed.state.nh.us/NHPublicSchools](http://www.ed.state.nh.us/NHPublicSchools)). All eighty-one (81) public high schools (See high schools list in Appendix A) were included in the sample. Our goal was to get at least one representative from each high school to answer our survey whose job included responsibility for students who had substance misuse issues,. We therefore generated a list of guidance directors, guidance counselors and school nurses from each school. Some of these names were available from school websites or by contacting the school by phone. If a name was not available, we addressed the questionnaire by title (i.e., School Nurse, "X" High School). We then ascertained which schools had a Student Assistance Program (SAP) or a specialized drug\alcohol counselors and sent questionnaires to all those we could identify. Our total sample was 240.

Data Collection - Questionnaires with cover letters were sent in early October, 2002. Self-addressed return envelopes were included. By early November, 2002, 59 questionnaires were returned representing 45 different schools. Reminder e-mails (and phone calls, if e-mailing was not possible) were undertaken and an additional 13 questionnaires, including 8 from previously unrepresented schools, were received by December 13, 2002.

To supplement the data received through the questionnaires, in-person interviews were conducted at a select group of schools by Dr. Zunz, Ms. Binette, or by both, using a format with established guiding questions (See Guiding Questions in Appendix A). Audiotaping and/or note taking were used during the in-person interviews to record responses. Attempts were made to conduct interviews at schools in geographically and socio-economically diverse parts of the state and to include knowledgeable representatives from various professions. Interviews were conducted at six (6) schools with 11 key school staffers including guidance directors, guidance counselors, school nurses, and SAP counselors.

Additionally, in-person interviews were conducted with key community informants in the Alcohol & Other Drugs (AOD) field in New Hampshire. The same guiding questions interview format that was used for in-person interviews with school personnel was used to interview the key informants. Four (4) people were interviewed including a representative from New Futures, the NH Division of Drug Abuse, Prevention & Recovery, Reclaiming Futures, and the State's Drug Court.

Data Analysis – Quantitative Data was analyzed using SPSS 11.0. Qualitative data was analyzed by transcribing the “guiding principle” interviews and then coding the

data to look for recurring categories or themes. Ms. Binette was the first to interpret the responses. To insure bias control, Ms. Binette's interpretations were then evaluated independently by Dr. Zunz. This same procedure was undertaken to examine any written comments by respondents that were included on the questionnaires themselves.

## **Findings**

Demographics – Questionnaires were received from at least one staff member at 53 different schools, representing almost 2/3 (65.4%) of all New Hampshire high schools. Of the total sample, 72 questionnaires were returned (30% of all school personnel solicited) indicating that we had 19 high schools where more than one staff member responded. Thus, for the 19 schools where more than one person responded, the respondents' scores were averaged to give each school a single score. (Statistical analysis demonstrated no statistically significant differences between multiple respondents from the same schools, verifying the validity of this averaging procedure). This procedure was undertaken to ensure that schools with multiple responders did not receive more weight in the analyses than schools with a single responder.

Seventy (70%) percent of the respondents were female (50) and respondents ranged in age from 23-58 years ( $m = 35$  yrs). Of the guidance counselors\directors in the sample, 24% (36 out of 150) responded and 31% (21 out of 68) of the nurses sent back their questionnaires. The best response rate was achieved from the SAP or Drug\Alcohol Counselors group where there was a 68% (15 out of 22) response rate.

Over two-thirds of the sample had Masters degrees (68.2%) with 22.7% having Bachelors degrees, and 3% having Doctorates. Forty-one (41%) percent of the sample

had degrees in counseling or guidance, 25% in nursing, 11% in psychology, and the rest in other fields including education and social work. College major made no significance difference in responses except that those with counseling or social work degrees saw students as more willing to accept services than those with degrees in nursing ( $F= 4.187$ ,  $p= .002$ ). Respondents had worked for the public schools from .5 – 35 years ( $m = 12.98$  yrs.) and had worked in their present school for .5-26 years ( $m = 7.89$  yrs.). Similar backgrounds were found with the 15 school and community key informants who were interviewed in person. Three-quarters of them had Masters degrees or higher and they had worked in the substance abuse field for a mean of 14 years. In summary, the sample was composed of individuals who were extremely well educated and had substantial experience working in the public schools and/or in the field of teen substance abuse.

Of the 53 schools in the sample, enrollments ranged from 70-3200 with a mean of 930 students (See graph in Appendix B). Slightly less than 1/3 (30.2%) of the schools were from the highest socio-economic districts in the state, 26.4% from the mid-range districts, and 43.4% from the lower socioeconomic areas (See Kids Count 2000 income charts in Appendix B). The poorer schools were most frequently found in the sample to be in the smaller, more rural school districts ( $\text{Chi square} = 19.92$ ;  $p= .001$ ).

#### Findings by Individual Respondents (n=72)

When asked how familiar they felt they were about the AOD problems in their school, respondents felt quite comfortable with their knowledge base. On a 10-point scale, responses ranged from 4.0-10.0 with a mean of 8.0 (See graph in Appendix B). These responses did vary significantly by profession ( $F=2.45$ ;  $p=.043$ ), with SAP

counselor's feeling more confident in their knowledge than school nurses. This finding is to be expected since substance abuse is the SAP staff's main concern while school nurses have a myriad of health issues to address in the course of their daily work.

Despite respondents' comfort with their knowledge, they seemed to have some difficulty answering questions about the percent of students in their school whose functioning was impaired by substances. Around half (48-55%) of respondents either did not answer the question or answered by saying they didn't know. Many wrote that it was difficult to know which substances were being used in their school or whether impairment in functioning was due solely to substance abuse or to such abuse in combination with other problems (learning disabilities, family problems, mood disorders, etc). Respondents also said that the way the question was asked (using the term "functioning is impaired") made it hard to answer. For example, some felt that a student might binge drink on a specific weekends, but still be considered to have "overall functioning" in school. A few respondents suggested that in any future research "functioning is impaired" should be specifically defined. Those who did respond estimated that the percent of students at their school impaired by alcohol was 17.3%; by other drugs was 10.4%, and 15.0% by alcohol along with other substances. In comparison to the statistics reported in national teen studies (Brown, 2001; Johnston, O'Malley, & Bachman, 2001; Lewin, 2002; NHSDA, 2001; ONDCP. 2001: PLNDP, 2002; US Dept. of HHS – SAMHSA, 2002) and in the NH TAP reports (UNH Coop. Ext, 2002), respondent's estimates seem to be in line on "other drug" abuse (marijuana, Ecstasy, cocaine, etc) but to be an underestimation of impairment caused by alcohol.

Aside from confidence in one's knowledge base, job title significantly influenced two other responses. SAP counselors and guidance personnel were more apt to say their school offered both counseling in general (Chi-square= 8.751, p=.012), and specifically group counseling (Chi square = 13.489, p=.001), than did the surveyed school nurses. SAP counselors were also significantly more optimistic about the students' willingness to accept services (F= 3.548, p=.008) than were guidance personnel or school nurses. The reasons for this disparity are unclear and would need to be further explored. For all other variables, job titles made no significant differences nor did any other demographic characteristics. It should be noted, however, that some comparisons could not be performed reliably due to the relatively small sample size of some subcategories.

There appeared to be a strong desire for additional knowledge and assistance in dealing with substance dependent students on the part of those who answered the survey. Almost 7/8 of the respondents (85.9%) indicated that if funding was available they'd be interested in a pilot project to help struggling students at their school and almost 3/4 (73.2%) of those surveyed said they would like to receive a copy of this study's report. In qualitative comments, the desire to find funding for key staff positions (specifically, an MSW school social worker or an SAP) was expressed. This is not surprising since less than half of the schools in the survey (41.5%) had specialized SAP or Drug Counselors.

#### Findings by School (n= 53)

Survey responses (when averaged to obtained one per school) indicated the perception that the most commonly abused drug in NH public high schools is alcohol with 70% (the other 30% named marijuana). Two-thirds of the sample (68.1%) listed

marijuana as the second most commonly abused substance at their school with Ecstasy listed by 48% of those who named a 3<sup>rd</sup> substance (n=29). Several other drugs were named in the second or third most commonly abused category but at much lower rates: Speed or Stimulants were mentioned by 14%, Cocaine by 12%, and Cold Remedies abuse by 10%, and Prescription drug abuse by 9%. These findings of alcohol as the “students drug of choice” followed by marijuana support the NH TAP survey findings where students themselves listed alcohol as the most frequently used substance (UNH Coop Ext., 2002). When asked about the number of students who abused multiple substances, the most common answers were under 10% (See graph in Appendix B).

The rate at which substance dependent students dropped out of school showed significant variance, from 1% -90% (m=17.54%). However, 20% of the responses by school indicated a lack of knowledge about their dropout rate because: 1) Such data was not collected; 2) It was collected but not shared due to confidentiality; or 3) Reasons students drop out were too multifaceted to attribute to a single cause. One respondent also said that (s)he was unsure whether to count students who dropped out due to family substance abuse problems when answering this question. There was also confusion noted by some responders over whether the question was asking how many students dropout because of substance abuse or how many substance abusing students eventually drop out.

As with the answers to the drop out question cited above, there was considerable variance in the answers to the question of how many students who are “special education coded” also had alcohol and/or other drug dependence (range from 1-80%, m = 17.95%).

Again, 24% of the school representatives said they did not know, either because this data was not collected or disseminated, or because differentially diagnosing substance related issues from other learning problems in adolescents is extremely difficult.

When asked how many students received counseling through their school, answers ranged from 10-100% with a mean of 41.72% (See chart in Appendix B). Interestingly, this was one of only a few areas in the study where demographics had a statistically significant difference (See chart in Appendix B). Poorer school district provided a significantly ( $F=3.273$ ,  $p=.047$ ) higher percentage of students ( $m=58.75\%$ ) with school based counseling than was provided by the wealthier districts ( $m=27.37\%$ ). Although initially somewhat surprising, qualitative responses seemed to point to a lack of community resources in the poorer, smaller, rural towns requiring schools to take a more active role vs. the wealthier towns which had both more available community resources as well as families with greater assets, including better health insurance coverage.

Of the counseling being offered through the school (See chart in Appendix B), the most commonly used modalities were Individual Counseling (85%) and Referrals to Outside Services (83%); although only a mean of 10% of students referred for community counseling were felt to actually be receiving it (See graph in Appendix B). Coordination with other involved community resources and Meetings with students and their families (both at 77%), Disciplinary Action (72%), and Group Counseling (57%) were the next most common services. Although over  $\frac{3}{4}$  of the programs said they referred to outside agencies and coordinating with community resources, problems with referrals and coordination were noted by several respondents. For example, respondents stated: "There are no continuing support services for students in our immediate area,"

“We have more community programs now but they have long waiting lists,” “Better insurance coverage would enable better access to services,” “There’s a real lack of readily accessible residential treatment programs for teens who need it,” “There are few treatment options available for adolescents with their families, especially intensive outpatient program. We have no where to refer once youth recognizes they have a problem,” and “There is a lack of healthy after-school activities in this community.”

Respondents were asked what kept their schools from offering more services to students manifesting substance abuse problems. The most commonly cited barriers were: 72.7% cited lack of counselor’s time; 68.2% said lack of adequate community resources with whom to partner; 56.5% mentioned lack of parental cooperation (including parents who are “in denial,” who feel “drinking is OK if they take the car keys”, and who tell the school to concentrate on the “bad kids and leave the good kids alone”); 50% felt their school had other priorities; and 31.8% felt students wouldn’t use the help even if they offered it. In a specific question about students’ willingness to accept services, responses varied from students being “Somewhat Unwilling” to “Very Willing” with a mean score near the mid-range at 5.68 (on a scale of 1-10).

Lesser barriers cited by schools were that they felt they didn’t really know how to help (13.6%) or that schools denied they had a substance abuse problem (8.7%). The most common barrier (11%) mentioned in the “Others” category can be summarized under the heading of “lack of administrative support.” Respondent included in this category comments such as: “Administrators and school board are reluctant to directly address these issues...too political,” “Our test scores are not what the school board would like so we lost our social worker to a reading specialist. There is a lack of value

seen in offering substance abuse intervention,” “The school board refused to allow us to conduct the YRBS to gather statistics about substance abuse,” “I think the school districts who have staff who wish to be drug/alcohol certified should contribute towards their training,” and “I want to run a group for parents with students with drug problems but haven’t been able to get support from administration.”

Questions of barriers to services were also asked during the in-person interviews conducted with key school and key community informants (n=15). Several of the same factors were named during in-person interviews as were described by those filling out the written questionnaires, although the order of importance was somewhat different (See graph in Appendix B for comparisons). Lack of community resources, especially residential placements and interagency, multidisciplinary teams to offer comprehensive screenings and treatment for students with dual\multiple problem areas, was mentioned as a barrier by 2/3 (n=10) of those during in-person interviews (66.6%). This was very similar to the frequency lack of community resources was mentioned in written questionnaires (68.2%). However, half (53.3%) of those interviewed in-person mentioned denial (on the part of the community, students, and parents) as an important barrier, 46.7% mentioned lack of adequate funding, and 1/3 mentioned both lack of teamwork\communication issues, and lack of adequate insurance as barriers.

About a quarter of the school representatives (26.3%) said they did not know if students were in community counseling since this information was not shared with school personnel. Of those who did respond (n=32), respondents reported between 1-50% of their substance dependent students are already receiving counseling in the community; however, the sample mean was only 10.22%. There was a significant difference in the

percent that received community counseling by school district economics with those who lived in middle income districts receiving more community based counseling than those in either poorer or wealthier districts (Chi-Square = 33.64, p=.029).

#### Findings from In-Person Interviews (n=15)

The school personnel and key informants were asked to “give a grade” to the efforts they saw to address the issues of substance dependent teens. School personnel tended to give these efforts a higher grade (ranging from “A” to “C+”) than did the key informants (grades ranged from “C” to “D”). Several respondents gave multiple grades. For example, one school-based interviewee said the school got an “A” or a “B” for their written policies but more like a “D” for what actually happened from a therapeutic standpoint. At another school, a respondent felt that their community referral system was an “A” but their in-house efforts deserved a “C.” The key informants gave the schools themselves a higher grade than they gave the State, which they unanimously felt was falling short of establishing a well funded and coordinated system of service delivery to substance dependent students.

During in-person interviews, respondents were asked to name specific model programs that they would recommend to other schools. More than one respondent specifically mentioned: Reconnecting Youth ([www.modelprograms.samhsa.gov](http://www.modelprograms.samhsa.gov)), Prime for Life ([www.askpri.org](http://www.askpri.org)), Dare to Be You ([www.coopext.colostate.edu](http://www.coopext.colostate.edu)), and a variety of adventure education, challenge course, or Outward Bound type projects. Respondents also mentioned the need to use programs with a proven research\outcome record like

those investigated by Drug Strategies ([www.drugstrategies.org](http://www.drugstrategies.org)), Robert Wood Johnson ([www.rwjf.org](http://www.rwjf.org)), and Center for Substance Abuse Treatment ([www.samhsa.gov/csats](http://www.samhsa.gov/csats)).

Program continuity was also consistently mentioned as critical by all those interviewed, including the desire for intervention to last at least one year with different levels of services available over time. Key informants from the four community groups supported the need for multiple levels of intervention, stressing the necessity of collaboration by schools, courts, state agencies, and community initiatives to work toward improving information dissemination, encouraging program innovations, and influencing both policy decisions and available funding.

#### Limitation of this Study

This preliminary study reports the findings of a survey of high schools from one Northern New England State. However, most school's viewpoint was represented by only one staff member, the poorer districts were somewhat over-represented, and each job title was not equally represented. Neither teachers, nor parents, nor students were included in this survey although their input has been solicited in the past by studies like the TAP surveys. In addition, questions were raised about the wording of a few questions, particularly with the need for a working definition of "functioning is impaired" and the impossibility of accurately answering questions that forced one to separate substance abuse from other co-existing problems that impair student functioning. Therefore, the findings of this study should not be assumed to have generalizability. However, this needs assessment took place in a relatively small state with at least one survey was received from 2/3 of the state's public high schools and 15 key informants

giving in-person interviews. Thus, the information gathered in this study might be used as a starting point to examine certain perceived programming strengths and shortfalls in addition to indicating areas for future research.

### Summary of Findings

This study's findings, based on information from 53 out of New Hampshire's 81 high schools and 15 key informants, points out many strengths about the efforts of the state's public high schools to assist their substance dependent students. For example, the personnel dealing with these issues had many years of experience both in particular high schools and in the substance abuse field. They were also highly educated, the vast majority having Masters degrees. School personnel also had a high degree of confidence in what they knew about substance abuse issues at their school, especially the SAP counselors. Respondents also indicated an interest in doing more, either receiving additional information (as reflected in the number who wanted copies of this report) and/or wishing to try innovative programming if a pilot project with connected resources was available. In addition, the vast majority of schools who offered services, offered a menu of counseling options, not holding "a one size fits all" view of student needs.

On the negative side, although alcohol continues to be cited as the number one abused substance in New Hampshire schools, respondents appeared to underestimate the number of students potentially impaired by its misuse. In addition, more than half of the schools did not have a specialized SAP or Drug Counselor, despite the fact that this study indicates such professionals were more confident in their knowledge base, more familiar with services, and more optimistic about outcomes than were other professionals dealing with substance dependent students. Also, it was noteworthy that although school

demographics played a smaller role in most areas than was anticipated, there was some disparity in that the poorer districts offered significantly more school based counseling, while middle income districts made more referrals to community agencies.

In terms of services available to students impaired by substance misuse, there was a wide variation in services available but the mean number of schools offering “in-house” services was less than 50%. Additionally, although  $\frac{3}{4}$  of the schools indicated they made referrals to community-based resources, only 10% of substance dependent students were actually using such services. Finally, both school personnel and key informants cited a long list of barriers to overcome if quality services are to be provided.

### **Where do we go from here?**

Our state’s public high schools are stressed by ever increasing demands. They have school budgets that do not keep up with these demands and that, in New Hampshire, are based on a property tax system found by the court to be disequitable. Thus, our schools, like most schools nationwide, are feeling increasing pressure to utilize their resources to produce “accountability” and “excellence” both in academic and non-academic programs paid for with taxpayer funds (Cassel, 2001; Skria et al, 2001). In this study we found New Hampshire school personnel are already offering individual and group counseling experiences to students in such a wide variety of areas as: prevention of bullying, developing conflict resolution skills, preventing dating violence and sexual harassment, and dealing with divorce. Therefore, with all they already do, plus with schools becoming increasingly conscious of their image in the community, high schools are reluctant to set themselves up as the scapegoat for our wider society’s

problems with alcohol and other drugs. They understandably see offering school based services for chemically dependent students as having an unfavorable cost/benefits ratio, i.e. serving a small percentage of their school population, requiring labor intensive interventions, and having hard to measure success rates. Thus, as this study indicates, although the state's public high schools are already trying to be "part of the solution" for substance dependent teens, they do not want to be looked to be "THE solution."

If schools are going to be "a part" of a broader community effort to help substance dependent teens, there is a need to help motivated schools work effectively in conjunction with local community service partners like health\mental health providers, child welfare agencies, or the juvenile justice system and drug courts. Such collaborations could provide or support students' treatment, encourage recovering students to finish school, work on co-existing problems with family and peers, and provide encouragement through relapses. Research demonstrates that such collaborative approaches to adolescent substance abuse treatment can be effective. For example, Hsieh et al. (2001) reported that community-based treatment programs are able to reduce adolescent substance abuse, improve school performance, and lower involvement in the criminal justice system. Williams et al. (2000) agrees that the most effective treatment programs for adolescents encourage completion of an initial, intense treatment protocol of at least 3 month's duration followed by a "wraparound" model of post-treatment aftercare services. However, implementation of such a coordinated, multi-systems approach is a time consuming process that requires collaboration on difficult issues such as: clarification of roles ("turf"); development of strategies to address information sharing and confidentiality concerns; creating programs that serve all segments of the

community; sufficient funding and insurance coverage; and making school\community collaborations a two-way street with clear benefits to participant groups (Sanders, 2001).

In addition to supporting greater community collaborations, what have other school systems done to support substance dependent students? Three of the most common modalities for the delivery of such services are briefly described below:

Student Assistance Programs (SAP) – Less than half of the schools in this study had Student Assistance Programs or specialized drug counselors. SAP's were first piloted almost 25 years ago and are found nationally to play a variety of roles from offering assistance in creating school policies, to staff education and development, to early identification of substance dependency problems, to both in-house counseling and referrals to community services (NASAP, 2002). SAP counseling services are typically offered in a group format and concentrate on reinforcing and monitoring commitment to reduction\elimination of substance misuse through: the identification of high risk situations and developing problem solving strategies to deal with them; stress management; relationship skill building; and strategies to deal with abstinence violations (NASAP, 2002; Wagner et al., 1999). Nationally, studies on the effectiveness of SAP services are limited but indicate that around 80% of those who attend regularly, decrease or stop their substance misuse (Moore & Forster, 1993; Wagner et al., 1999).

School-based for-credit programs - Although this study did not identify any for-credit programs in New Hampshire public high schools, there are examples in other states of such a for-credit program based in the student's home school. One example, the *Adolescent Post-Treatment Support: A High School Substance Recovery Course* (Ferguson, 2001), is a school-based, independent study course developed in the

Milwaukee, Wisconsin area in the late 90's in response to the number of students who were relapsing when they returned to their regular high school after treatment. This course begins with a school meeting immediately after a recovering student finishes treatment including the student, parents, and a teacher-mentor. A contract is agreed upon which the teacher-mentor then oversees in regular meetings with the student. The teacher-mentor also acts as a liaison with the student's other teachers, which is important if the student has a history of academic difficulties. Parents\guardians are also included in the communication loop; their report on the success of the "home" elements of the contract is included in every student's course grade. Students also receive credit towards their grade for verified hours that they attend family or individual counseling, 12-step meetings, or any other sanctioned treatment activity that supports their recovery.

The coursework in this program is set up to focus on activities of recovery, while also meeting the academic rigors found in other for-credit high school courses. Students have homework, written assignments, midterm exams, and final papers. An example of similar for-credit coursework can be found in the service learning programs now popular in many high schools (Greenberg, 2000; Manhood & Romer, 2001).

Recovery\Alternative Schools – When a student's home school feels it cannot meet the needs of a substance dependent student, the student is often referred to an alternative school program. In the 1990's, at least 4 million students a year attended such programs (Weller, et al, 1999) and several of the schools in this study mentioned referrals to alternative educational facilities from traditional GED programs to night schools. In other areas of the country, there are targeted programs for substance dependent teens called "Recovery Schools." There are currently about twenty such Recovery Schools in

nine states (Finch, 2002). Recovery Schools are either charter or private schools which require all attending students to be sober and working a program of recovery. Recovery Schools offer academic courses for which students receive credit and provide assistance to make the transition into college, a career, or back to their home school. Recovery Schools, as is true for many alternative school programs, may provide recovery\post-treatment support, but they do not operate primarily as mental health agencies.

Alternative high school programs for recovering students have met with mixed results. Attending students exhibit high-risk behaviors in conjunction with their substance dependence which make effective programs very service intensive and thus costly, as much as \$10,000 per student per year (Diehl, 2002; Weller et al., 1999). Although students who stay in alternative schools for a full school year demonstrate improvement, many attempts to sustain individual programs have failed due to personnel problems, lack of public support, and\or financial challenges (Diehl, 2002).

New Hampshire high schools and the communities they serve can assess whether community collaborations along with any of the models described above might work best for them. The first step, however, is the need for a school and its community to decide if they wish to make a public commitment to play a part in establishing services for substance dependent students. This means gathering together all constituent groups (parents, students, school social workers, guidance counselors, school administrators, school board members, and the school district's citizens) and deciding that post-identification support will have a place in their school district's mission. Once such a commitment has been made, the following are some suggestions for next steps to set up effective programming:

1. Become knowledgeable about an increasingly sophisticated research base on best practice options for substance dependent teens.

Physician Leadership on National Drug Policy (2002) describes the state of our current research based knowledge as follows: “We are entering a renaissance of research...The number of studies evaluating formal substance abuse treatment programs for adolescents doubled from 1997-2001 and promises to double again within the next three years. There are more adolescent treatment studies in the field now than there were completed in the field’s history through 1997” (p. 31). Resources on effective programs are available through research institutes like Drug Strategies ([www.drugstrategies.org](http://www.drugstrategies.org)) or through government websites like the one maintained by the Substance Abuse and Mental Health Services Administration ([www.samhsa.gov](http://www.samhsa.gov)). For example, Drug Strategies’ (2003) recent publication presents nine (9) key elements that effective teen treatment programs should possess (pg. 4):

- 1) Good assessments and treatment matching;
- 2) Comprehensive and integrated approaches;
- 3) Family involvement;
- 4) Age and developmentally appropriate programming;
- 5) Treatment approaches that engage and retain teens;
- 6) Qualified and trained staff;
- 7) Programs that demonstrate gender and cultural competence;
- 8) Continuation of care in the post-treatment period to monitor relapses and ensure community supports are in place;
- 9) Sound outcome evaluation plans that enhance efforts at both accountability and quality service delivery.

They cited one New Hampshire program, The Nashua Youth Council, as a program that met its effectiveness standards.

2. Need to tailor approaches through good assessments that fit specific adolescents and their specific community.

As most of our high schools already demonstrate, there is no “one-size-fits-all” approach. Local high schools are in a good position to use their expertise about their particular students and their particular community. Good program planning begins with an identification process that assesses factors in each individual student such as: biological stage of development, ability to think abstractly, formation of an independent sense of self, type of peer influences, level of sensation seeking behavior, and development of non-substance related coping skills (PLNDP, 2002). Schools already possess a great deal of this information, which could form the basis for a sound assessment of an individual student’s needs. Schools are also well aware of the availability (or unavailability) of community resources, such as: prevention programming, support for the transition from middle to high school, and recreational options that can supply non-use activities for all students in general as well as for students in recovery. Schools can also help to assess and develop a continuum of care, which includes school supports in addition to community based treatment options.

### 3. Fight for funding and parity in insurance coverage.

Even if schools have the commitment, knowledge base, and assessment skills to become part of the provision of post-identification support services for their students, it is not possible to undertake such efforts without financial and staffing resources. There is a need to press for clarity and/or changes in special education covered services available to students with disabilities attributable to substance dependence. Similarly, there is a need to fight for parity in insurance coverage. Many families are uninsured, have insurance that does not cover substance related treatment, or have insurance that provides only a small, capped dollar amount for such services. Although Medicaid and CHIP services

are available to cover treatment services for some teens, the reimbursement rate is very low which is a disincentive to the development of community programs with which schools might collaborate (American Academy of Pediatrics, 2001). Parity in funding for treatment by both public and private insurers as well as state agencies would help students and their families gain access to needed services (Strum, 2001).

4. Need to resolve barriers to school-community collaboration.

Although there is agreement that continuum of care or “wraparound” services are the best approach to treating substance dependent students (Doweiko, 2002; Kaminer, 2001), such a continuum of care requires a functioning school-community treatment coalition. Coalitions often look easier to establish on paper than in practice. If coalitions are to be successful, groundwork needs to be done to resolve potential conflicts over issues such as roles, expertise, and staff qualifications; the development of interagency and interdisciplinary trust; and the format to be used for communication among participants that respects confidentiality (Altshuler, 2003; Pollio, 2002).

In conclusion, we hope this report has documented the many areas of aid to substance dependent students in which New Hampshire public high schools are already making a contribution. In a climate of limited and competing resources, a variety of services are already being provided through schools and community agencies. We hope the information in this report will help individual schools and communities, as well as state policy makers, examine where we currently stand, vision where we might want to go, and possess the tools to take the first steps to get to the place where every substance dependent teen in NH has access to the quality services they need and deserve.

## References

- Altshuler, S. (2003). From barriers to successful collaboration: Public schools and child welfare working together. *Social Work*, 48(1), 52-63.
- American Academy of Pediatrics Committee on Child Health Financing and Committee on Substance Abuse (2001). Improving substance abuse prevention, assessment, and treatment financing for children & adolescents. *Pediatrics*, 108(4), 1025-30.
- Annie E. Casey Foundation (2000). *Kids Count 2000: NH County, City Community-Level Information*. Retrieved 3/10/03 from [www.aecf.org](http://www.aecf.org).
- Brown, J. (2001). Youth, drugs and resilience education. *Journal of Drug Education*, 31(1), 83-122.
- Cassel, R. (2001). High school accountability means the personal development and Academic achievement of all students. *Education*, 121(4), 836-845.
- Diehl, D. (2002). Recovery High School. In S. Issaacs & J. Knickman, eds. *To improve health & health care, Volume V* (Chapter 7). Princeton, NJ: Robert Wood Johnson Foundation.
- Doweiko, H. (2002). *Concepts of chemical dependency, 5<sup>th</sup> ed.* Pacific Grove, Calif: Brooks Cole.
- Drug Strategies (2003). *Treating teens: A guide to adolescent drug programs*. Washington, DC: Drug Strategies. Information also retrieved 3/7/03 from [www.drugstrategies.org](http://www.drugstrategies.org).
- Ferguson, N. (2001). *Adolescent post-treatment support: A high school substance Recovery course*. Holmes Beach, Florida: Learning Publications.
- Finch, A. (2002). *Discovering solutions to the nation's alcohol and other drug problems*. Nashville, Tenn: Association of Recovery Schools. Retrieved 1/10/03 from [www.recoveryschools.org](http://www.recoveryschools.org).
- Gonet, M. (1990). A three-pronged approach to substance abuse prevention in a school system. *Social Work in Education*, 12(3), 208-217.
- Greenberg, R. (2000). They learn from those they serve. *Techniques: Connecting Education and Careers*, 75(8), 18-22.
- Hsieh, Y., Grella, C., Hubbard, R., Hsieh, S., Fletcher, B., Brown, B., & Anglin, D. (2001). An evaluation of drug treatment for adolescents in 4 U.S. cities. *Archives of General Psychiatry*, 58(7), 689-695.

- Johnston, L., O'Malley, P. & Bachman, J. (2001). *National survey results on drug use from the monitoring the future study*. Rockville, Md: U.S. Dept. of Health & Human Services.
- Kaminer, Y. (2001). Adolescent substance abuse treatment: Where do we go from here? *Psychiatric Services*, 52(2), 147-149.
- Lewin, T. (2002, February 27). Disturbing finding on young drinkers proves to be wrong. *New York Times* – National Section. Retrieved 3/5/02 from [www.nyt.com](http://www.nyt.com).
- Liddle, H. (2002, May). The research renaissance in adolescent substance abuse treatment. *Connection* (newsletter of the Academy for Health Services Research and Health Policy), 4-5.
- Manhood, S. & Romer, A. (2001). The hospice teen volunteer program at the Hospice of the Florida Suncoast. *Journal of Palliative Medicine*, 4(1), 117-119.
- Moore, D. & Forster, J. (1993). Student assistance programs: New approaches for reducing adolescent substance abuse. *Journal of Counseling & Development*, 71(3), 326-330.
- National Association of Student Assistance Professionals (2002). *Student assistance program components*. Retrieved 9/1/02 from <http://www.nasap.org>.
- National Center on Addiction & Substance Abuse (2002, August). *National survey of American attitudes on substance abuse VII: Teens, parents, and siblings*. New York: NCASA- Columbia Univ.
- National Center on Addiction & Substance Abuse (2001, Sept.). *Malignant Neglect: Substance Abuse and America's Schools*. New York: NCASA- Columbia Univ.
- National Household Survey on Drug Abuse (2001). *Substance Abuse- A national challenge: Prevention treatment and research at HHS*. Retrieved 2/24/02 from <http://www.samhsa.gov/oas>
- Office of National Drug Control Policy (2001). *Drug facts: Juveniles and drugs*. Retrieved on 2/24/02 from <http://www.whitehousedrugpolicy.gov>.
- Pacific Institute for Research & Evaluation (1999). *Strategies to reduce underage alcohol use: Typology and brief overview*. Retrieved 8/20/02 from [www.udetc.org](http://www.udetc.org).
- PLNDP - Physician Leadership on National Drug Policy (2002). *Adolescent substance abuse: A public health priority*. Providence, RI: Brown University's Center for Alcohol and Addictions Studies.

- Pollio, D. (2002, May). States need to ensure expertise of adolescent treatment providers through training and certification. *Connection*, 6-7.
- Sanders, M. (2001). The role of community in comprehensive school, family, and community partnership programs. *Elementary School Journal*, 102(1), 19-34.
- Substance Abuse and Mental Health Services Administration (2003). SAMHSA model programs: Effective substance abuse and mental health programs for every community. Retrieved 1/20/03 from [www.modelprograms.samsha.gov](http://www.modelprograms.samsha.gov).
- Schydlower, M. & Anglin, T. (1995). The role of schools in combating substance abuse. *Pediatrics*, 95(5), 784-786.
- Skria, L., Scheurich, J., & Johnson, Jr. (2001). Toward a consensus on high academic achievement for all children. *Education & Urban Society*, 33 (3), 227-235.
- Strum, R. (2001). The cost of covering mental health and substance abuse care at the same level as medical care. Retrieved 1/20/02 from [www.rand.org/publications/CT/CT180](http://www.rand.org/publications/CT/CT180).
- University of New Hampshire Cooperative Extension (2002). *Teen Assessment Project (TAP) 2000-2001 Multi-Community Report*. Durham, NH: UNH Coop Ext.
- U.S. Department of Health & Human Services – Substance Abuse and Mental Health Administration (2002). 2001 National Household Survey on Drug Abuse. Retrieved 9/19/02 from [www.samhsa.gov/oas/nhsda](http://www.samhsa.gov/oas/nhsda).
- Wagner, E., Borwn, S., Monti, P., Myers, M., & Waldron, H. (1999). Innovations in Adolescent substance abuse intervention. *Alcoholism: Clinical and Experimental Research*, 23(2), 236-249.
- Weller, N., Tortolero, S., Kelder, S., Grunbaum, J., Carvajal, S. & Gingiss, P. (1999). Health risk behavior of Texas students attending dropout prevention/recovery schools in 1997. *Journal of School Health*, 69(1), 22-29.
- Williams. R., Chang, S., and Addiction Centre Adolescent Research Group (2000). A comprehensive and comparative review of adolescent substance abuse treatment outcome. *Clinical Psychology*, 7 (2), 138-166.

