The Recovery Revolution:
Will it include children, adolescents, and transition age youth?

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Executive Summary

Systems transformation efforts to shift addiction treatment from a model of acute stabilization to a model of sustained recovery management and to nest addiction treatment within a larger recovery-oriented system of care are underway at federal, state, and local levels, but these innovations to date have focused on the redesign of adult services. This paper explores the potential and limitations of recovery as an organizing concept for services to children, adolescents, and transition age youth, and offers recommendations on how services for these populations can be integrated into recovery- and resiliency-focused, behavioral health care systems transformation efforts.

Recovery Revolution Defined

- Since 2004, the City of Philadelphia has been engaged in a recovery-focused behavioral health care systems transformation process that has mobilized the community around a recovery vision and begun aligning concepts, service practices, and contexts (e.g., regulatory policies, funding mechanisms) to support that vision.
- Federal, state, and local behavioral health policy and planning bodies are now evaluating the extent to which recovery can be used as an organizing concept for child and adolescent (C & A) services.
- There is growing consensus to create a recovery-oriented system of care for youth that is family-driven, developmentally appropriate, culturally nuanced, highly individualized, and focused on youth resilience, strengths, and empowerment.
- Questions remain about the potential advantages and disadvantages of the recovery concept applied to C & A services and how that concept can be integrated with the existing concepts that have been used to guide the design of C & A services.
- These questions will be explored as they relate to *children*, *adolescents*, and *transition age-youth.*

Historical Context: Recovery and Age of Onset of Alcohol and Drug Use

- The most socially and clinically significant American drug trend of the past century is the lowered age of onset of alcohol and other drug use.
- Lowered age of initial AOD use is linked to greater risk of developing a substance use disorder, the speed of problem progression and severity of consequences, and greater levels of post-treatment relapse.
- The average age of onset of AOD use of adolescents entering addiction treatment is now below age 13.
- The concept of recovery is more applicable to children, adolescents, and transition-age youth now than at any previous time in the country's history.

Family Recovery

- Child development can be adversely affected by AOD-related problems of their parents or siblings, and children in AOD-affected families are at increased risk for developing such problems as well as experiencing other adverse developmental outcomes.
- The recovery of a parent with AOD-related problems enhances the health and developmental outcomes of his or her children.
- Interventions are available that enhance the recovery and resilience of children negatively impacted by parental substance dependence.

Recovery of Adolescents and Transition Age Youth

- In 2008, 8% of youth aged 12-17 and 21% of transition age youth met diagnostic criteria for a substance use (alcohol or illicit drugs) disorder, but less than one in ten youth received specialized addiction treatment.
- There are more than 4,900 treatment programs that specialize in the treatment of adolescent substance use disorders. There has also been an increase in youth-focused recovery mutual aid meetings.
- The earlier the intervention for a substance use disorder (in terms of both age and months/years of use), the better the long-term recovery outcomes.
- There are evidence-based, brief therapies that are effective for many substance-involved adolescents, but most adolescents are precariously balanced between recovery and relapse in the months following such therapy.
- Recovery stability is enhanced by sustained post-treatment monitoring, support, and if needed, early re-intervention, but such extended care and support is rare.
- The concept of recovery seems to be a viable one for adolescents seeking to reconstruct their lives following significant and sustained AOD-related problems.

Conceptual Frameworks for Organizing Child and Adolescent Services

- The concepts of "system of care," "wraparound services," "positive youth development," and "resilience" have served as organizing frameworks for C & A services in recent decades.
- Resilience is the achievement of positive developmental outcomes in spite of personal and environmental risk factors.
- Resilience-based systems of youth development seek to reduce risk factors and increase protective factors at personal, family, and environmental levels.
- Resistance is: 1) an innate hardiness that allows one to be exposed to an infectious agent without becoming ill, and/or 2) the act of desisting or ceasing AOD use as an act of cultural or political survival.
- Recovery from a substance use disorder entails three critical ingredients: sobriety, global health (physical, cognitive, emotional, relational, spiritual), and citizenship.
- These elements of recovery have yet to be fully defined for youth.

Recovery Management and Recovery-Oriented Systems of Care

- *Recovery management* (RM) is a philosophy of organizing addiction treatment and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery.
- *Recovery-oriented systems of care* (ROSC) encompass the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families affected by AOD problems and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes.
- Approaches to RM and ROSC for adults and for youth share many elements in common.
- Efforts are currently underway (as this report indicates) to identify what distinctive changes in services for children, adolescents, and transition age youth occur within the movement to RM and ROSC.

Shared Characteristics of Organizing Concepts

- Rather than think of recovery and resilience in either/or terms, it may be helpful to think of systems transformation guided by both resilience and recovery.
- Child and family advocates in many places have embraced these concepts as complementary.

Primary Prevention, Early Intervention, Treatment, and Recovery Support

- Addiction treatment and recovery support services for parents constitute a strategy of prevention for their children.
- These strategies can be further amplified by involving children in the treatment of their parent and by providing specialized services designed to enhance the child's recovery from the developmental insults of parental addiction and to enhance the child's future resilience and resistance related to AOD-related problems.
- The treatment of every adult parent should include child-focused prevention and early intervention services aimed at breaking the intergenerational transmission of AOD-related problems.
- RM and ROSC involve an integration of primary prevention, early intervention, treatment, and recovery support services.

Recovery Concept and Children: Advocates

- Advocates of applying the recovery concept to C & A services extol the concept's holistic, developmental perspective; emphasis on hope, empowerment, and choice; integration of spirituality as a healing/protective force; emphasis on thriving rather than just symptom remission; compatibility with system of care and positive youth development approaches to youth service design; inclusion of such issues as historical trauma and social stigma; and its emphasis on the role of social connectedness in adolescent health.

Recovery Concept and Children: Critics

- Critics of applying the recovery concept to C & A services contend that recovery: is misapplied to children because of its meaning of returning to a previous level of functioning; brings with it the social stigma attached to addiction; lacks a holistic, developmental perspective because of its "disease" trappings; and works only if integrated with the concept of resilience.

The Philadelphia Focus Groups

- Focus groups with providers, parents, and youth felt that recovery and resilience were compatible concepts that both called for developmentally-informed models of care, family inclusion/direction and leadership, peer support and leadership, a continuum of support, community integration and mobilization of community recovery/resiliency support resources, trauma-informed care (and addressing violence within the trauma framework), and culturally competent care.
- A group of youth much discussed in the Philadelphia focus groups was transition age youth who were "aging out" of the child service system with little transitional support when they were no longer eligible to continue receiving services. It was hoped that new approaches to such transition planning could be developed given the ROSC emphasis on long-term, stage-appropriate recovery support.

The Voices of Youth

- Voices from the youth focus groups pleaded for a system of care that would see them as individuals rather than a disorder and relate to them from a position of respect and authenticity.

Summary and Recommendations

- The report ends with a set of recommendations in the following areas: concepts and language of systems transformation, representation and leadership, recovery visibility of youth, collaboration and partnership, a continuum of (personal/family/community) recovery support, practice guidelines, assessment and treatment/recovery planning, recovery-focused treatment, youth-focused peer recovery culture, and evaluation of effects of systems transformation on C & A and C & A Service Providers.
- These recommendations are intended as a framework for continued discussions regarding the future of C & A services within the City of Philadelphia.

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> *Comprehensive systems to facilitate recovery for adults with substance abuse and/or mental health concerns have been conceptualized and operationalized in a number of states and communities across the United States and in other countries. To date there has been little discussion or research on how these adult-focused concepts apply to adolescents.*[1]

The governing concepts of the addictions field are rapidly shifting from a focus on pathology and professional treatment to the lived experience of long-term recovery. Phrases such as *recovery management* (RM) and *recovery-oriented systems of care* (ROSC) reflect a paradigmatic shift in the design and delivery of addiction treatment. *Systems transformation* efforts reflecting this new long-term recovery perspective are underway at federal, state, and local levels.[2] These initiatives are generating considerable excitement within the addictions field, but are to date limited by their emphasis on the redesign of adult addiction treatment and innovations related to peer-recovery support services for adults. The purpose of this paper is to explore the potential and limitations of recovery as an organizing concept for services to children, adolescents, and transition age youth. The paper explores a variety of potential organizing concepts and ends with a series of recommendations on how children, adolescent, and transition age youth services can be fully integrated into recovery- and resiliency-focused, behavioral health care systems transformation efforts.

Recovery Revolution Defined

For the past five years, the City of Philadelphia has been at the center of two national shifts in behavioral health care. The first is the emergence of *recovery* as an organizing concept for the design and delivery of addiction treatment and other behavioral health care services.[3] The second is an effort to extend addiction treatment

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[1] Cavanaugh. D., Goldman, S., Friesen, B. and Bender, C. (2008). *Designing a recovery-oriented care model for adolescents and transition age youth with substance use and co-occurring mental health disorders*. Prepared for the CSAT/CMHS/SAMHSA Recovery Consultative Meeting, November 13-14, 2008.

[2] White, W. (2008). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care*. (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

[3] Gagne, C. A., White, W., & Anthony, W. A. (2007). Recovery: A common vision for the fields of mental health and addictions. *Psychiatric Rehabilitation Journal, 32*(10), 32-37. White, W. (2005) Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, *23*(1), 3-15.

from models of acute biopsychosocial stabilization or palliative care to a model of active and sustained recovery management[4] and to nest these services within larger "recovery-oriented systems of care."[5] The contextual influences that set the stage for this "recovery revolution" include the growth, philosophical diversification, and geographical dispersion of recovery mutual aid societies (including online recovery communities); the cultural and political awakening of people in recovery from behavioral health disorders via a renewed advocacy movement; and increased recovery community building activities, e.g., the growth of grassroots recovery community organizations, community recovery centers, recovery homes, recovery schools, recovery industries, and recovery ministries.[6]

In 2004, the City of Philadelphia committed itself to a major recovery-focused transformation of its behavioral health care system under the new leadership of Dr. Arthur Evans, Jr. Table 1[7] identifies several distinguishing elements of the "Philadelphia Model" of behavioral health care systems transformation.

Table 1: Creating a Recovery-Oriented System of Care: The Philadelphia Model

System Dimension	Philadelphia Model
Recovery Vision	Resources are allocated to support the recovery vision (wellness, wholeness, quality, and meaningfulness of life) for individuals, families, and neighborhoods. All policy-makers and clinical decision-makers undergo ongoing, recovery-focused training and supervision.
Varieties of Recovery Experience	Service planners and providers acknowledge the legitimacy of multiple pathways and styles of long-term recovery from behavioral health disorders and promote a philosophy of choice within their service relationships.
Systems Level Recovery Management	Behavioral health care is managed by a publicly-owned entity responsible for the effective stewardship of public behavioral health care dollars and the strategic allocation of resources to support the long-term recovery of individuals and families whose lives have been disrupted by behavioral health disorders.
Behavioral Health	Recovery is used as a conceptual bridge for the increased

White, W. (2008). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000.

[4] McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13), 1689-1695. White, W. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

[5] White, W. (2008a). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care*. (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

[6] White, W.L. (2007). A recovery revolution in Philadelphia. *Counselor*, *8*(5), 34-38.

[7] Excerpted from McLaulin, B., Evans, A.C., & White, W. (2009). The role of addiction medicine in a recovery-oriented system of care. Unpublished manuscript.

Care Integration	integration of professionally-directed mental health services, professionally-directed addiction treatment services, peer-based recovery support services, and primary health care.
Systems Integration	Federal, state, county, and municipal resources are coordinated to generate increased resources, strategically allocate resources, and provide regulatory relief.
Service Accessibility	Service entry is accessible, efficient, respectful, and warmly welcoming: all system elements are devoted to the goal of rapid and gracious service engagement.
Global Assessment	Assessment is comprehensive, strengths-based, continual, family-inclusive, and encompasses assessment of each client's recovery environment.
Service Quality and Responsiveness	Services are developmentally appropriate, gender-specific, culturally competent, trauma-informed, family-focused, and evidence-based.
Indigenous Resources	Services at all levels of care include assertive linkage to indigenous communities of recovery (recovery support groups) and recovery community service institutions (recovery community centers, recovery homes, recovery ministries, recovery advocacy organizations).
Continuity of Support	All primary treatment services are followed by post-treatment monitoring and support, stage-appropriate recovery education, active recovery coaching, and when needed, early re-intervention.
Systems Performance Monitoring and Evaluation	Recovery-focused systems performance data and the ongoing guidance of key stakeholders are used to guide the continued systems transformation process.
Systems Health	The ability of a behavioral health care system to enhance the health of those it serves is only as good as the health of service providers and the service infrastructure. Active efforts are made to enhance the health and performance of service providers and service organizations.

Table 2[8] summarizes key ideas that have guided this process of system-wide change.

Table 2: Philadelphia System Transformation Implementation Principles/Strategies

1. Partnership: Relationships within the system—from service relationships to institutional relationships—shift from authority-based to respect-based and emphasize stakeholder representation, participation, collaboration, and multi-directional communication.

[8] Excerpted from McLaulin, B., Evans, A.C., & White, W. (2009). The role of addiction medicine in a recovery-oriented system of care. Unpublished manuscript.

2. New Ideas, New Language, New Technologies: Systems transformation is driven by a set of kinetic (change-eliciting) ideas, a new language, and new planning and service technologies that are recovery-focused.
3. Core Values: Decisions are based on the values of hope; choice; empowerment; peer culture, support, and leadership; partnership; community inclusion/opportunities; spirituality; family inclusion and leadership; and a holistic/wellness approach.
4. Openness and Transparency: Decisions at all levels of the system—from clinical decisions to policy and funding decisions—are transparent and consistent with previously defined values, policies, and plans.
5. Planned Synergism: Multiple staged initiatives are used to complement one another to achieve magnified effects.
6. Minimalism: Existing structures are used or renewed when possible; the goal is the minimal level of organization needed to achieve a task; wide use of short-term ad hoc groups to study, decide, design, create, and disband; preference for development and use of local expertise.
7. Management of Resistance: Resistance to change at all levels is viewed as a normal part of the systems change process and is actively managed.
8. Change Facilitation: System transformation is facilitated by training, process consultation, and technical assistance at all levels of the service delivery system.

As these tables illustrate, the behavioral health care systems transformation process in Philadelphia involves efforts aimed at conceptual alignment (core values and principles), contextual alignment (system policies and relationships), and practice alignment—all directed toward support of long-term recovery for individuals and families. The history, goals, and strategies of this process have been described in a series of earlier publications.[9]

Those readers with any significant tenure in health and human service systems will have witnessed the rise and fall of many newly proclaimed organizing concepts. Seen in this historical context, it is difficult to determine whether an emerging concept

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[9] Achara-Abrahams, I., Kenerson, J., & Evans, A.C. (in press). Recovery-focused behavioral health system transformation: A framework for change and lessons learned from Philadelphia. In J. Kelly, & W. White (Eds.), *Addiction recovery management: Theory, science and practice*. Totowa., New Jersey: Humana Press, Inc. DBH/MRS (2007). *Recovery-focused transformation of behavioral health services in Philadelphia: A declaration of principles and a blueprint for change*. Philadelphia: Department of Behavioral Health and Mental Retardation Services. Retrieved from http://www.phila.gov/dbhmrs/initiatives/index.html. DBH/MRS (2007). *An integrated model of recovery-oriented behavioral health care.* Philadelphia: Department of Behavioral Health and Mental Retardation Services. Retrieved from http://www.phila.gov/dbhmrs/initiatives/INT_index.html. Evans.A.C., & Beigel, A. (2006). *Ten critical domains for system transformation: A conceptual framework for implementation, evaluation and adaptation*. Presented at the 16th Annual Conference on State Mental Health Agency Services Research, Program Evaluation & Policy, February, Baltimore, MD. Evans, A. (2007). The recovery-focused transformation of an urban behavioral health care system. Retrieved June 26, 2007 from http://www.glattc.org/Interview%20With%20Arthur%20C.%20Evans,%20PhD.pdf. Lamb, R., Evans, A.C., & White, W. (2009). The role of partnership in recovery-oriented systems of care: The Philadelphia experience. Unpublished Manuscript. White, W.L. (2007). A recovery revolution in Philadelphia. *Counselor*, *8*(5), 34-38.

adds something fundamentally new and valuable or whether it represents a repackaging of old ideas into a new rhetoric.[10] Huffine[11] has raised the question of whether all this new rhetoric—transformation, resilience, recovery, evidence-based practices—constitutes a sign of real change or "the latest ways to put lipstick on a pig"—a cosmetic attempt to beautify failing service systems. Even the most viable of concepts can be lost in the rapidly evolving arena of behavioral health care. Early discussions of systems transformation always evoke feelings of déjà vu and skepticism.

> *I've lived through many administrations and the focus always changes: this month we're supposed to be doing XXX and next month it's YYY. What's going to happen when the focus changes away from recovery and resilience?*[12]
>
> *Why focus practice guidelines on recovery and resilience? Ten years from now it will be changing. What are we doing to look and plan for future changes?*[13]

An effective organizing concept—what Room[14] calls a "governing image"—must "work" at multiple levels. It must help individuals and families impacted by severe AOD problems make sense of their lives via processes of story construction and storytelling, e.g., "disclose in a general way what we used to be like, what happened, and what we are like now".[15] It must provide a framework to guide the service activities of addiction professionals and recovery support specialists. It must provide a framework for service program design, development, and replication. It must guide policy makers and funding organizations in their macro-level responses to AOD problems. It must help the general public understand, prevent, and respond to such problems. A concept must achieve all of these things across diverse populations and cultural contexts and prove adaptable to changing conditions over time.

It is then not surprising that any governing image used to respond to an intractable problem is inherently unstable.[16] The inevitable imperfection of fit—concepts that work at some but not all of these levels, concepts that work for some populations and within some cultures but not others, concepts that once seemed to work in the past but seem not to presently work—has generated a long history of conceptual instability within the AOD problems arena in the United States.

As the Philadelphia systems transformation process unfolded over the past five years, questions were raised about how this transformation process and the concept of

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[10] Rutter, M. (2006). Implications of resilience concepts for scientific understanding. *Annals of New York Academy of Science*, *1094*, 1-12.

[11] Huffine, C. (2006). A new concept of mental health: A focus on strengths. *Iceberg Newsletter*, September, 2-4.

[12] Philadelphia Caregiver Focus Group Participant, 2009

[13] Philadelphia Caregiver Focus Group Participant, 2009

[14] Room, R. (1978). *Governing images of alcohol and drug problems: The structure, sources and sequels of conceptualizations of intractable problems.* Ph.D. Dissertation, Berkeley, CA: University of California.

[15] Alcoholics Anonymous (1939). Proposal to form the One Hundred Men Corporation to publish the book *One Hundred Men*. (Reprinted 1991). Wheeling, WV: The Bishop of Books.

[16] Room, R. (1978). *Governing images of alcohol and drug problems: The structure, sources and sequels of conceptualizations of intractable problems.* Ph.D. Dissertation, Berkeley, CA: University of California.

recovery upon which it rests applies to particular service populations and to particular service modalities. For example:

- Where do primary prevention and early intervention services fit within an ROSC?
- What are the shared and distinguishing characteristics of the concepts of resilience and recovery?
- Where does medication-assisted treatment fit within a recovery-oriented system of care—if at all?
- What roles, if any, do harm reduction (e.g., needle exchange programs) and risk reduction (e.g., DUI programs) play within a recovery-oriented system of care?

As the change process within Philadelphia's behavioral health care system proceeds, there is growing consensus that it needs to go "deeper" (achieving greater depths of change in policies and service practices) and "wider" (embracing service populations and service organizations that have not been fully involved in the transformation process). Questions like the above and the question of how all this relates to children and adolescent services are part of this "deeper" and "wider" process.

The exploration of how systems transformation would affect children and adolescent services was raised early in the transformation process in Philadelphia. A child and adolescent (C & A) subcommittee was created within the Office of Addiction Services Advisory Board to assure the inclusion of goals and objectives related to C & A services.[17] As the transformation process proceeded, greater concern has been voiced about whether the concept of recovery adds anything new to alcohol- and other drug-related (AOD) services for children, adolescents, transition age youth, and their families as well as the future of C & A services within an ROSC.

The concerns raised in Philadelphia about application of the recovery concept to children's services have been mirrored in a series of national meetings. In 2005, the Center for Substance Abuse Treatment (CSAT) hosted a recovery summit that included discussion of the application and potential misapplication of the concept of recovery to adolescents. In November 2008, a national "recovery consultative session" was hosted by CSAT and the Center for Mental Health Services (CMHS) to explore the design of a "recovery-oriented system of care for adolescents and transition age youth" with a substance use or co-occurring mental health disorder. In March 2009, a "national dialogue on families of youth with substance use addiction" engaged affected families and representatives from the Substance Abuse and Mental Health Services Administration (SAMHSA). The latter two meetings addressed problems of service access and quality for substance-affected youth and families, the untoward effects of addiction-related social stigma, and the need for a broad and sustained spectrum of clinical and recovery support services to buttress adolescent recovery through the developmental transition into adulthood. Meeting participants called for a recovery-oriented system of care for youth to be family-driven, developmentally appropriate, culturally nuanced, highly individualized, and focused on youth resilience, strengths, and empowerment.[18]

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[17] See http://www.dbhmrs.org/assets/Forms--Documents/4.2.1.2-OAS-Goals-Objectives-Board-Final-Draft-20080620.pdf

[18] Cavanaugh. D., Goldman, S., Friesen, B., & Bender, C. (2008). *Designing a recovery-oriented care model for adolescents and transition age youth with substance use and co-occurring mental health*

It is noteworthy that the appropriateness and degree of applicability of recovery as an organizing concept for behavioral health services for children and adolescent services tend not to be raised at national, state, or local levels as a major concern until systems transformation processes are well underway.[19] This paper is intended as a stimulus for continued discussion of this issue in Philadelphia and at a national level. It will review scientific studies and professional commentaries on recovery as an organizing concept for services to youth, summarize the results of national and local focus groups that have been hosted to address this question, and offer recommendations to guide our continued work in Philadelphia.

Recovery-related concepts require substantial adaptation across the developmental life cycle.[20] To add specificity to the coming discussions, we will apply these concepts and principles to three distinct developmental groups: *children*, *adolescents*, and *transition age-youth* (also referred to as *emerging adults*).[21] The precise definitions of the three groups vary considerably in the professional and popular literature. In this paper, children will be defined as persons under the age of 13; adolescents will be defined as persons between the ages of 13 and 17; and transition age youth will be defined as persons between the ages of 18 and 25.

Historical Context: Recovery and Age of Onset of AOD Use

There is a long history of concern about alcohol and other drug use among youth in the United States,[22] but the thought of a person in recovery from alcohol or other drug addiction has not historically elicited images of children or adolescents. Until recently, the primary focus on children has been in the arenas of prevention and early intervention and the effects of parental AOD use on children. That focus began to change with the rise of juvenile narcotic addiction following World War II and shifted further during the dramatic rise of youthful drug experimentation in the 1960s and 1970s.[23]

The most socially and clinically significant American drug trend of the past century is the lowered age of onset of alcohol and other drug use.[24] By the early 1990s, more than one third of drug-using youth incarcerated within state-operated juvenile

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disorders. Prepared for the CSAT/CMHS/SAMHSA Recovery Consultative Meeting, November 13-14, 2008.

[19] Davidson, L., O'Connell, M.J., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services*, *57*(5), 640-645. Evans, A. (2007). The recovery-focused transformation of an urban behavioral health care system. Retrieved June 26, 2007 from http://www.glattc.org/Interview%20With%20Arthur%20C.%20Evans,%20PhD.pdf. Kirk, T. (2007). Creating a recovery-oriented system of care. In W. White (Ed.), *Perspectives on systems transformation*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

[20] White, W. (2006). Recovery across the life cycle. *Alcoholism Treatment Quarterly, 24*(1/2), 185-201.

[21] Tanner, J.L. (2006). Recentering during emerging adulthood: A critical turning point in life span human development. In J.J. Arnett, & J.L. Tanner (Eds.), *Emerging adults in America: Coming of age in the 21st century* (pp. 21-55). Washington D.C.: American Psychological Association.

[22] White, W. (1999). The history of adolescent alcohol, tobacco and other drug use. *Student Assistance Journal*. *11*(5), 16-22.

[23] White, W., Dennis, M., & Tims, F. (2002). Adolescent treatment: Its history and current renaissance. *Counselor, 3*(2), 20-23.

[24] White, W., Godley, M., & Dennis, M. (2003). Early onset of substance abuse: Implications for student assistance programs. *Student Assistance Journal, 16*(1), 22-25.

facilities reported onset of drug use before age 12 (19% before age 10).[25] A 2005 study of children in foster care found that more than one-third of older children met diagnostic criteria for a substance use disorder.[26] A 2004 study—the largest randomized trial of adolescent treatment ever conducted—revealed that 85% of adolescents entering addiction treatment in the United States begin regular use of alcohol and other drugs before age 15.[27] Seen as a whole, age-related prevalence for substance use disorders sharply rises after age 12 and peaks between ages 18-23, suggesting that the prodromal period for these disorders often spans late childhood and early and middle adolescence.[28] Adding to this import is the finding that the earlier age at which a substance use disorder is treated, the better the long-term outcome.[29]

It is difficult to overemphasize the clinical and social significance of lowered age of onset of AOD use, particularly pre-adolescent onset, and the importance of early prevention and early intervention services. Lowered age of initial AOD use is linked to:

- increased probability of subsequent multiple drug use,[30]
- increased risk of developing a substance use disorder,[31]

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[25] U.S. Department of Justice, Bureau of Justice Statistics. (1994). *Drugs and Crime Facts, 1994.* Retrieved from http://www.ojp.usdoj.gov/bjs/dcf/contents.htm.

[26] Vaughn, M., Ollie, M., McMillen, C., Scott, L., & Munson, M. (2005, January). *Patterns of substance use among older youth in foster care*. Presented at the Society for Social Work and Research Conference, Miami, FL. Amodeo, M., & Collins, M.E. (2007). Using a positive youth development approach in addressing problem-oriented youth behavior. *Families in Society: Journal of Contemporary Social Services*, *88*(1), 75-85.

[27] Dennis, M.L., Godley, S.H., Diamond, G.S., Tims, F.M., Babor, T., Donaldson, J., Liddle, H., Titus, J.C., Kaminer, Y., Webb, C., Hamilton, N., & Funk, R.R. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment, 27*, 197-213.

[28] Dennis, M.L., White, M.K., & Ives, M. (2009). Individual characteristics and needs associated with substance misuse of adolescents and young adults in addiction treatment. In C.G. Luekefeld, T.P. Gullotta, & M. Staton-Tindall (Eds.), *Adolescent substance abuse: Evidence-based approaches to prevention and treatment*. New York: Springer. Enoch, M. (2006). Genetic and environmental influences on the development of alcoholism. *Annals of the New York Academy of Science*, *1094*, 193-201. Palmer, R.H.C., Young, S.E., Hopfer, C.J., Corley, R.P., Stallings, M.C., Crowley, T.J., & Hewitt, J.K. (2009). Developmental epidemiology of drug use and abuse in adolescence and young adulthood: Evidence of a generalized risk. *Drug and Alcohol Dependence*, *102*, 78-87.

[29] Dennis, M.L., Scott, C.K., Funk, R., & Foss, M. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment*, *28*(Supplement 1), S51-S62. M.L., White, M.K., & Ives, M. (2009). Individual characteristics and needs associated with substance misuse of adolescents and young adults in addiction treatment. In C.G. Luekefeld, T.P. Gullotta, & M. Staton-Tindall (Eds.), *Adolescent substance abuse: Evidence-based approaches to prevention and treatment*. New York: Springer.

[30] Kandel, D.B. (1982). Epidemiological and psychosocial perspectives on adolescent drug use. *Journal of American Academic Clinical Psychiatry*, *21*, 328-347. McGue, M., Iacono, W.G., Legrand, L.N., & Elkins, L. (2001). Origins and consequences of age at first drink: I. Associations with substance-use disorders, disinhibitory behavior and psychopathology, and P3 amplitude. *Alcoholism: Clinical and Experimental Research*, *25*, 1156-1165.

[31] Chou, S. P., & Pickering, R. P. (1992). Early onset of drinking as a risk factor for lifetime alcohol-related problems. *British Journal of Addiction, 87,* 1199-1204. Grant, B. F., & Dawson, D. A. (1997). Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence. *Journal of Substance Abuse, 9,* 103-110. Dennis, M. L., Babor, T., Roebuck, M. C., & Donaldson, J. (2002). Changing the focus: The case for recognizing and treating marijuana use disorders. *Addiction*, *97*, S4-S15. Sartor, C.E., Lynskey, M.T., Bucholz, K.K., Madden, P.A.F., Martin, N.G., & Heath, A.C. (2009). Timing of first alcohol use and alcohol dependence: Evidence of common genetic influences. *Addiction*, *104*(9), 1512-1518.

- telescoping of the progression of AOD-related problems,[32]
- greater problem severity and complexity—including greater cognitive impairment, liver dysfunction, and probability of a co-occuring psychiatric illness,[33]
- increased risk of school failure,[34]
- increased lifetime risk of accidents while under the influence of alcohol,[35]
- increased risk of perpetration of and victimization by alcohol-related violence,[36] and
- compromised intervention outcomes, e.g., decreased probability of discontinuance of drug use, less help-seeking, and greater post-intervention relapse.[37]

The risks associated with lowered age of onset are not ameliorated by social class or educational achievement and appear to be amplified in the transition between adolescence and young adulthood, e.g., 20.6% of full-time college students meet diagnostic criteria for an alcohol use disorder, and 7.9% meet criteria for a drug use disorder.[38]

Alcohol- and other drug-related problems rise throughout adolescence, peak at a 20% prevalence rate between ages 18-20, and progressively decline over subsequent

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[32] Dewit, D.J., Adlaf, E.M., Offord, D.R., & Ogborne, A.C. (2000). Age of first alcohol use: A risk factor for the development of alcohol disorders. *American Journal of Psychiatry*, *157*, 745-750. Kreichbaun, N., & Zering, G. (2000). Adolescent patients. In G. Zering (Ed.), *Handbook of alcoholism* (pp. 129-136). Boca Raton, LA: CRC Press.

[33] Arria, A. M., Dohey, M. A., Mezzich, A. C., Bukstein, O. G., & Van Thiel, D. H. (1995). Self-reported health problems and physical symptomatology in adolescent alcohol abusers. *Journal of Adolescent Health, 16*(3), 226-231. National Institute on Alcohol Abuse and Alcoholism. (2003). Underage drinking: A major public health challenge. *Alcohol Alert, 59,* 1-7. Sobell, M. B., Sobell, L. C., Cunningham, J. C., & Agrawal, S. (1998). Natural recovery over the lifespan. In E. L. Gomberg, A. M. Hegedus, & R. A. Zucker (Eds.), *Alcohol problems and aging* (NIAAA Research Monograph No. 33, pp. 397-405). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.

[34] Gruber, E., DiClemente, R.J., Anderson, M.M., & Lodico, M. (1996). Early drinking onset and its association with alcohol use and problem behavior in late adolescence. *Preventative Medicine*., *25,* 293-300.

[35] Hingston, R. W., Heeren, T., Jananka., A., & Howland, J. (2000). Age of drinking onset and unintentional injury involvement after drinking. *Journal of the American Medical Association, 284,* 1527-1533.

[36] Hingston R. W., Heeren T., & Zakocs R. (2001). Age of drinking onset and involvement in physical fights after drinking. *Pediatrics, 108*(4), 872-877. Mrug, S., & Windle, M. (2009). Initiation of alcohol use in early adolescence: Links with exposure to community violence across time. *Addictive Behaviors*, *34,* 779-781.

[37] Kandel, D.B., Single, E., & Kessler, R. (1976). The epidemiology of drug use among New York State high school students: Distribution, trends, and changes in rates of use. *American Journal of Public Health, 66*, 43-53. Keller, M., Lavori, P., Beardslee, W., Wunder, J., Drs., D., & Hasin, D. (1992). Clinical course and outcome of substance abuse disorders in adolescents. *Journal of Substance Abuse Treatment, 9,* 9-14. Kessler, R. C., Aguilar-Gaxiola, S., Berglund, P., Caraveo-Anduaga, J., DeWitt, D., Greenfield, S., Kolody, B., Offson, M., & Vega, W. (2001). Patterns and predictors of treatment seeking after onset of a substance use disorder. *Archives of General Psychiatry, 58*(11), 1065-1071. Chen, J., & Millar, W. (1998). Age of smoking initiation: Implications for quitting. *Health Reports, 9*(4), 39-46.

[38] Wu, L., Pilowsky, D.J., Schlenger, W.E., & Hasin, D. (2007). Alcohol use disorders and the use of treatment services among college-age young adults. *Psychiatric Services*, *58*(2), 192-200.

decades.[39] In 2007, 133,742 adolescents were admitted to specialty sector addiction treatment in the United States, and a total of 464,323 youth under age 25 were admitted to such treatment.[40] In a recent analysis of 14,776 adolescent addiction treatment admissions, Dennis, White, and Ives[41] found the average age of first AOD use was 12.6 years, with 73% reporting onset of use between ages 10 and 14. This same review found that adolescents had used alcohol and other drugs an average of 3.2 years prior to their admission to treatment. Also noteworthy are studies concluding that certain patterns of adolescent AOD use (e.g., multiple drug use) are more resistant to positive forces of maturing out and are markers for potentially prolonged addiction and psychiatric careers, e.g., drug use disorders of adolescents and a drug use disorder co-occurring with an anxiety disorder or depression.[42]

From a historical perspective, the concept of recovery has greater applicability to adolescents and transition age youth today than at any time in American history. The concern is that most of what we know about recovery is derived from studies of adults. We know very little about the prevalence, pathways, processes, and stages of long-term recovery for adolescents with substance use disorders.[43] That paucity of understanding is reflected in acute care models of intervention into adolescent substance use disorders that lack sustained recovery support and that all too often leave adolescents and families feeling abandoned at discharge.[44] What is needed are long-term studies that illuminate how particular clinical and peer support interventions as well as particular developmental milestones in the transition into adulthood (e.g., leaving home, college, marriage or cohabitation, employment, parenthood) affect trajectories of resilience, addiction, and recovery among high-risk youth.[45]

Family Recovery

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[39] Dennis, M. L., & Scott, C.K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*(1), 45-55.

[40] SAMHSA (2008). National Survey on Drug Use and Health. Trends in Substance Use, Dependence or Abuse, and Treatment among Adolescents: 2002 to 2007. Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA).

[41] Dennis, M.L., White, M.K., & Ives, M. (2009). Individual characteristics and needs associated with substance misuse of adolescents and young adults in addiction treatment. In C.G. Luekefeld, T.P. Gullotta, & M. Staton-Tindall (Eds.), *Adolescent substance abuse: Evidence-based approaches to prevention and treatment*. New York: Springer.

[42] Palmer, R.H.C., Young, S.E., Hopfer, C.J., Corley, R.P., Stallings, M.C., Crowley, T.J., & Hewitt, J.K. (2009). Developmental epidemiology of drug use and abuse in adolescence and young adulthood: Evidence of a generalized risk. *Drug and Alcohol Dependence*, *102*, 78-87.

[43] White, W., & Godley, S. (2007). Adolescent recovery: What we need to know. *Student Assistance Journal*, *19*(2), 20-25.

[44] Center for Substance Abuse Treatment. (2007). *National Summit on Recovery: Conference Report* (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration. *Blamed and Ashamed.* (2001). Alexandria, VA: Federation of Families for Children's Mental Health. White, W., Dennis, M., & Godley, M. (2002). Adolescent substance use disorders: From acute treatment to recovery management. *Reclaiming Children and Youth*, 11(3), 172-175.

[45] For a representative study, see D'Amico, E.J., Ramchand, R., & Miles, J.N.V. (2009). Seven years later: Developmental transitions and delinquent behavior for male adolescents who received long-term substance treatment. *Journal of Studies on Alcohol and Drugs*, *70*, 641-651.

The concept of *family recovery* has significant applicability to children, adolescents, and transition age youth. Family recovery from the impact of a substance use disorder encompasses five dimensions:

- improvement of personal health and functioning of each family member,
- improvement in the quality of subsystem relationships (adult intimate relationships, parent child relationships, sibling relationships),
- increased clarity and consistency of family roles, rules, and rituals,
- enhanced quality and flexibility of external boundary transactions (the family's relationship with outside kinship and social networks), and
- reduction of risk for intergenerational transmission of AOD addiction and related problems.[46]

Addiction as a Family Disorder: Prolonged and excessive AOD use by a family member can impair family functioning and the personal development and global (physical, emotional, relational) health of individual family members.[47] The adverse effects of childhood exposure to parental addiction may be worse in families that remain intact than in families in which the child is abandoned by the alcoholic parent.[48] Children may also be negatively affected by exposure to sibling substance use, e.g., increased risk of early substance experimentation and subsequent problem development.[49] Same-generation family members (siblings, cousins) can constitute a risk for substance use or a protection against substance use based on their substance-related attitudes and behaviors.[50] This risk can be ameliorated by involving siblings in the treatment of their brother or sister.[51]

Childhood Risk and Resilience: Most children and adolescents rebound from the effects of an adverse childhood environment. Most (60-75%) children of alcohol-

[46] White, W., & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly, 23*(4), 3-37; White, W. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

[47] Beardslee, W.R., Son, L., & Vaillant, G.E. (1986). Exposure to parental alcoholism during childhood and outcome in adulthood: A prospective longitudinal study. *British Journal of Psychiatry*, *149*, 584-591. Steinglass, P. (1993). *The alcoholic family*. Hutchinson Education.

[48] McCord, J. (1990). Long term perspectives on parental absence. In L.N. Robins, & M. Rutter (Eds.), *Long term perspective on parental absence* (pp. 116-134). Cambridge: Cambridge University Press.

[49] For a brief review see: Bamberg, J.H., Toumbourou, J.W., & Marks, B. (2008). Including siblings of youth substance abusers in a parent-focused intervention: Pilot test of the Best Plus Program. *Journal of Psychoactive Drugs*, *40*(3), 281-291.

[50] Waller, M.A., Okamoto, S.K., Miles, B.W., & Hurdle, D.E. (2003). Resiliency factors related to substance use/resistance: Perceptions of Native adolescents in the Southwest. *Journal of Sociology and Social Welfare*, *30*, 79-94. Brook, J.S., Whiteman, M., Gordon, A.S., & Brook, D.W. (1988). The role of older brothers in younger brothers' drug use viewed in the context of parent and peer influences. *Journal of Genetic Psychology*, *137*, 133-142.

[51] Bamberg, J.H., Toumbourou, J.W., & Marks, B. (2008). Including siblings of youth substance abusers in a parent-focused intervention: Pilot test of the Best Plus Program. *Journal of Psychoactive Drugs*, *40*(3), 281-291.

dependent parents will not go on to develop AOD problems,[52] but children who have experienced sustained exposure to severe parental addiction and/or mental illness can suffer profound developmental effects and are in greatest need of indicated prevention and early intervention services.[53]

- There is a clear but complex relationship between parental addiction, neglect, and maltreatment of children and the subsequent emotional and behavioral health of children.[54]
- Children, particularly male children, of alcohol/drug-dependent parents are at increased risk of developing these same problems as well as other developmental problems.[55]
- Children of alcohol dependent parents have 4-10 times the risk of experiencing an alcohol use disorder in their lifetimes compared to children without these genetic/environmental risk factors.[56]
- The mechanisms driving risk for intergenerational transmission of AOD problems include biological/genetic vulnerabilities, parental modeling, child/family distress, inadequate conveyance of coping skills, positive alcohol expectancies (particularly for males), and increased environmental availability of AOD.[57]

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[52] Beardslee, W.R., Son, L., & Vaillant, G.E. (1986). Exposure to parental alcoholism during childhood and outcome in adulthood: A prospective longitudinal study. *British Journal of Psychiatry*, *149*, 584-591. Pandina, R.J., & Johnson, V. (1989). Familial drinking history as a predictor of alcohol and drug consumption among adolescent children. *Journal of Studies on Alcohol*, *50*, 245-254.

[53] Werner, E.E. (2004). Journeys from childhood to midlife: Risk, resiliency and recovery. *Pediatrics*, *114*(2), 492.

[54] Blau, G.M., Whewell, M.C., Gullotta, T.P., & Bloom, M. (1994). The prevention and treatment of child abuse in households of substance abusers: A research demonstration progress report. *Child Welfare*, *73*(1), 83-94. White, W., Woll, P., & Webber, R. (2003) *Project SAFE: Best Practices Resource Manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse.

[55] Bennett, L.A., Wolin, S.J., Reiss, D., & Teitelbaum, M.A. (1987). Couples at risk for transmission of alcoholism: protective influences. *Family Process*, *26*, 111-129. Goodwin, D.W. (1988). *Is alcoholism hereditary?* New York: Ballantine Books. Merikangas, K.R., Stolar, M., Stevens, D.E., Goulet, J., Preisig, M., Fenton, B., Zhang, H., O'Malley, S., & Rounsaville, B.J., (1998). Familial transmission of substance use disorders. *Archives of General Psychiatry*, *55*, 973-979. Russell, M. (1990). Prevalence of alcoholism among children of alcoholics. In M. Windle, & J.S. Searles (Eds). *Children of alcoholics: Critical perspectives* (pp. 9-38), New York: Guildford Press. Schuckit. M.A. (2009). An overview of genetic influences in alcoholism. *Journal of Substance Abuse Treatment*, *36*(Suppl), S5-S-14.

[56] Enoch, M. (2006). Genetic and environmental influences on the development of alcoholism. *Annals of the New York Academy of Science*, *1094*, 193-201. Goodwin, D.W. (1988). *Is alcoholism hereditary?* New York: Ballantine Books. Russell, M. (1990). Prevalence of alcoholism among children of alcoholics. In M. Windle, & J.S. Searles (Eds). *Children of alcoholics: Critical perspectives* (pp. 9-38), New York: Guildford Press. Sher, K.J. (1993). Children of alcoholics and the intergenerational transmission of alcoholism: A biopsychosocial perspective. In J.S.. Baer, G.A. Marlatt, & R.J. McMahon (Eds), *Addictive behavior across the life span* (p. 3-33), Newbury Park: Sage Publications. Vitaro, F., Dobkin, P.L., Carbonneau, R. & Tremblay, R.E. (1996). Personal and familial characteristics of resilient sons of alcoholics. *Addiction*, 91(8), 1161-1177.

[57] Handley, E., & Chassin, L. (2009). Intergenerational transmission of alcohol expectancies in a high-risk sample. *Addictive Behaviors*, *70*, 675-682.

- Children of alcohol/drug dependent parents are also at risk for "indirect recurrence" via a process of "assortative mating" through which they select intimate partners who have or are likely to develop AOD problems.[58]

Parental Recovery and Child Development: Key aspects of family life disrupted by addiction continue to be disrupted during the early years of recovery.[59] For example, child maltreatment by an addicted parent recedes in tandem with recovery initiation, but development or re-establishment of a healthy parent-child relationship can be a prolonged process.[60] Recovery initiation, by suddenly destabilizing family roles, rules, rituals, and relationships, exerts strain on family members and the family system as a whole. Such strain can result in emotional/behavioral problems in children, pose threats to adult intimate relationships, and threaten family stability.[61] Support provided to a family through the transition from active addiction to stable recovery can enhance the development and emotional health of children in the family.[62] Family- and couples-focused treatment generates improved child adjustment outcomes superior to those found in treatments that focus solely on the individual with the substance use disorder.[63]

"Alcohol abuse has pervasive [negative] effects on spouses and children, but these effects diminish or even disappear entirely when the alcoholic family member is recovering."[64] Multiple studies confirm the improved health of the children of a substance-dependent parent who enters and sustains a recovery process.[65] The chain of

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[58] Bennett, L.A., Wolin, S.J., Reiss, D., & Teitelbaum, M.A. (1987). Couples at risk for transmission of alcoholism: protective influences. *Family Process*, *26*, 111-129. Grant, J.D., Heath, A.C., Bucholz, K.K., & Madden, P.A. (2007). Spousal concordance for alcohol dependence : Evidence for assortative mating or spousal interaction effects? *Alcoholism: Clinical and Experimental Research, 31*(5), 717-728. Hall, R.L, Hesselbrock, V.M., & Stabenau, J.R. (1983). Familial distribution of alcohol use: II. Assortative mating of alcoholic probands, *Behavior Genetics, 13*(4), 373-382. Olmsted, M.E., Crowell, J.A., & Waters, E (2003). Assortative mating among adult children of alcoholics and alcoholics. *Family Relations*, *52*(1), 64-71.

[59] Brown, S. (1994). What is the family recovery process? *The Addiction Letter, 10*(10), 1, 4. Brown, S., & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model.* New York & London: Guilford Press.

[60] White, W., Woll, P., & Webber, R. (2003) *Project SAFE: Best Practices Resource Manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse.

[61] Brown, S., & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model.* New York & London: Guilford Press.

[62] Brown, S. (1994). What is the family recovery process? *The Addiction Letter, 10*(10), 1, 4. Brown, S., & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model.* New York & London: Guilford Press.

[63] Powers, M.B., Vedel, E., & Emmelkamp, P.M.G. (2008). Behavioral couples therapy (BCT) for alcohol and drug use disorders: A meta-analysis. *Clinical Psychology Review*, *28*(6), 952-962.

[64] Moos, R.H., Finney, J.W. & Cronkite, R.C (1990). *Alcoholism Treatment: Context, process and outcome.* Oxford University Press; O'Farrell, T.J., & Feehan, M. (1999). Alcoholism treatment and the family: Do family and individual treatments for alcoholic adults have preventative effects for children. *Journal of Studies on Alcohol*, *Supplement 13*, 125-129.

[65] Burdzovic, A.J, O'Farrell, T. J., & Fals-Stewart, W. (2006). Does individual treatment for alcoholic fathers benefit their children? A longitudinal assessment. *Journal of Consulting and Clinical Psychology, 74*, 191–198; Callan, V.J., & Jackson, D. (1986). Children of alcoholic fathers and recovered fathers: Personal and family functioning. *Journal of Studies on Alcohol*, *47*, 180-182. Kelley, M.L., & Fals-Stewart, W. (2002). Couples- versus individual-based therapy for alcohol and drug abuse: Effects on children's psychosocial functioning. *Journal of Consulting and Clinical Psychology*, *70*, 417-427. Moos,

influence behind such improvement seems to be professional treatment, which increases AA or other mutual aid attendance, which enhances abstinence rates, which in turn generate improvements in the behavioral health of the children of those treated.[66] These effects are present even when children are not directly involved in family/child-oriented treatment processes.

There are a growing number of interventions designed to enhance protective/resiliency factors in children exposed to AOD problems within their families that could be integrated into mainstream addiction treatment.[67] Some treatment programs, such as the Betty Ford Center, have invested considerable resources in developing a child-focused service and support track for the children of parents treated at the Center.

There is a rapidly accumulating body of scientific evidence that addiction and recovery each exert a profound influence on the family in general and on children in particular. In spite of this evidence, services provided by the mainstream addiction treatment system for those affected by severe AOD problems range from non-existent, to "reactive, poorly thought out and marginal,"[68] to exemplary models that have yet to be widely replicated. It remains to be seen whether defining the roles of family and children within recovery-oriented systems of care will alter this bleak appraisal.

Recovery of Adolescents and Transition Age Youth

Discussing recovery in the context of adolescent and young adult substance use disorders rests on several critical points.

Problem Prevalence and Help-Seeking: In 2007, 317,279 adolescents (under the age of 18) and 330,581 transition age youth (18-24) were admitted for specialized addiction treatment in the United States.[69] 7.9% of youth aged 12-17 met diagnostic criteria for a substance use (alcohol or illicit drugs) disorder, but less than one tenth (7.6%) of those youth received specialized addiction treatment in the past year.[70] More than one fifth (21.1%) of transition age youth (aged 18-25) met diagnostic criteria for a substance use (alcohol or illicit drugs) disorder, but less than one tenth (7%) received specialized addiction treatment in the past year.[71] The profile of transition age youth most

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R.H., & Billings, A.G. (1982). Children of alcoholics during the recovery process: Alcoholics and matched control families. *Addictive Behaviors*, *7*, 155-163.

[66] Burdzovic Andreas, J.B., & O'Farrell, T.J. (2009). Alcoholics Anonymous attendance following 12-step treatment participation as a link between alcohol-dependent fathers' treatment involvement and their children's externalizing behaviors. *Journal of Substance Abuse Treatment, 36*, 87-100.

[67] Finkelstein, N., Rechberger, E., Russell, L.A., VanDeMark, N.R., Noether, C.D., O'Keefe, M., Gould, K., Mockus, S., & Rael, M.V. (2005). Building resilience in children of mothers who have co-occurring disorders and histories of violence. *The Journal of Behavioral Health Services and Research*. *32*(2), 141-154.

[68] Copella. A., & Orford, J. (2002). Addiction and the family: Is it time for services to take notice of the evidence. *Addiction*, *97*, 1361-1363.

[69] SAMHSA/OAS 2009, Personal communication with Dr. James Collier.

[70] SAMHSA/OAS 2009 Personal communication with Dr. James Collier.

[71] Substance Abuse and Mental Health Services Administration, Office of Applied Studies (June 25, 2009). *The NSDUH Report: Young adults' need for and receipt of alcohol and illicit drug use treatment, 2007*. Rockville, MD: Author.

in need of treatment is that of a young adult male with a family income of less than $20,000 or more than $75,000 who does not perceive himself as needing treatment.[72]

Specialized Resources for Adolescent Treatment and Recovery: Treatment and recovery support resources for adolescents have grown explosively in the past three decades.[73] The SAMHSA-sponsored 2000 National Survey of Substance Abuse Treatment Services[74] provided a window into the rapidly growing network of adolescent treatment programs in the United States. Of the 13,428 addiction treatment programs that participated in the survey, 4,969 provided services to adolescents. Adolescent treatment services were provided by 37% of private non-profit facilities, 36% of private for-profit facilities, 34% of state-operated facilities, and 65% of tribal owned facilities.[75]

There is also a growing network of young peoples' recovery support meetings and internet-based social networking/support sites for youth[76] as well as newly developed, assertive procedures aimed at enhancing linkage, engagement, and ongoing participation in such groups.[77]

Adolescent Treatment and Recovery Outcomes: A recent review[78] of adolescent treatment outcome research drew several important conclusions, including the following:

1. Many adolescents mature out of substance-related problems in the transition into adult role responsibilities; for other adolescents, substance-related problems evolve into a chronic, debilitating disorder.
2. Adolescents who mature out of substance-related problems often do so without conceptualizing these problems and their resolution within an addiction/recovery framework.
3. Factors that increase risk and inhibit maturing out include a family history of AOD problems, early age of initiation of regular use, co-occurring emotional/behavioral problems, and a low level of positive family and peer support.
4. The earlier the intervention (in terms of both age and months/years of use), the better the long-term recovery outcomes.
5. There are evidence-based, brief therapies that are effective for many substance-involved adolescents.
6. Viewed as a whole, the most common outcomes of adolescent treatment are enhancements in global functioning (increased emotional health and improved

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[72] Substance Abuse and Mental Health Services Administration, Office of Applied Studies (June 25, 2009). *The NSDUH Report: Young adults' need for and receipt of alcohol and illicit drug use treatment, 2007*. Rockville, MD: Author.

[73] White, W., Dennis, M., & Tims, F. (2002). Adolescent treatment: Its history and current renaissance. *Counselor, 3*(2), 20-23.

[74] Office of Applied Studies (OAS) (2000). *Substance Abuse and Mehtanl Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS), October, 2000*.

[75] Office of Applied Studies (OAS) (2000). Substance Abuse and Mehtanl Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS), October, 2000.

[76] Passetti, L., & White, W. (2008). Recovery meetings for youth. *Journal of Groups in Addiction and Recovery, 2*, 97-121.

[77] Passetti, L. L., & Godley, S. H. (2008). Adolescent substance abuse treatment clinicians' self-help meeting referral practices and adolescent attendance rates. *Journal of Psychoactive Drugs, 40*, 29-40.

[78] Risberg, R., & White, W. (2003) Adolescent substance abuse treatment: Expectations versus outcomes. *Student Assistance Journal, 15*(2), 16-20.

functioning in the family, school, and community) and reduced substance use (to approximately 50% of pre-treatment levels) rather than complete and enduring cessation of alcohol and other drug use.

7. All treatment programs are not the same: programs with the best clinical outcomes: a) treat a larger number of adolescents, b) have a larger budget, c) use evidence-based therapies, d) offer specialized educational, vocational, and psychiatric services, e) employ counselors with two or more years experience working with adolescents, f) offer a larger menu of youth-specific services (e.g., art therapy, recreational services), and g) are perceived by clients as empathic allies in the long-term recovery process.
8. Most adolescents are precariously balanced between recovery and relapse in the months following addiction treatment.[79] The period of greatest vulnerability for relapse is in the first 30 days following treatment; adolescents' status at 90 days following treatment is highly predictive of their status at one year following treatment.
9. Recovery stability is enhanced by post-treatment monitoring and periodic recovery checkups.[80]
10. The adolescent's post-treatment peer adjustment is a major determinant of treatment outcome. Adolescents who experience major relapse have the highest density of substance users in their post-treatment social milieu.
11. The post-treatment home environment also plays a significant role in recovery/relapse outcomes.
12. Recovery mutual aid networks (AA, NA, etc.) can offer considerable support for long-term recovery, but they suffer from low teen participation rates, and their effect is dependent upon intensity and duration of participation.

The Phenomenology of Adolescent Recovery: The concept of recovery seems to be a viable one for adolescents seeking to reconstruct their lives following significant and sustained AOD-related problems.[81]

Conceptual Frameworks for Organizing Child and Adolescent Services

There are multiple concepts that have served or could serve as an organizing framework for the design of child and adolescent (C & A) services.

System of Care: The concept of "system of care" has provided an organizing framework for the modern reform of children's mental health services.[82] System of care

[79] Godley, S.H., Dennis, M.L., Godley, M.D., & Funk, R.R. (1999). Thirty-month relapse trajectory cluster groups among adolescent discharged from out-patient treatment. *Addiction*, *99*(Suppl 2), 129-139.

[80] Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, *23*, 21-32. Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2006). The effect of assertive continuing care on continuing care linkage, adherence, and abstinence following residential treatment for adolescent substance use disorders. *Addiction*, *102*, 81-93.

[81] Long, W., & Vaughn, C. (1999). "I've had too much done to my hear'" The dilemma of addiction and recovery as seen through seven youngsters' lives. *Journal of Drug Education*, *29*(4), 309-322.

values and principles grew out of the recognition that the prevailing model of mental health care for children suffered serious problems related to attraction and accessibility, restrictiveness, and isolation from other youth and family services. There was also concern that prevailing models of care suffered from paternalism (failure to involve youth in decisions related to their own care), family exclusion (blame rather than invitation for service participation), and a lack of understanding about cultural differences across youth and families being served. What emerged was a vision of a youth/family-focused, comprehensive, coordinated, and community-based "system of care" for children and families needing mental health care and new planning frameworks (e.g., "wraparound" approaches) to create such a system of care.[83]

In April 2003, the CSAT Strengthening Communities for Youth Performance Monitoring Work Group identified nine "system of care" principles that should be applied to the design of treatment for adolescent substance use disorders. The Work Group concluded that such care should be:

- family and youth focused,
- culturally competent,
- partnership (interagency/intra-agency) guided,
- coordinated/collaborative,
- community-based,
- accessible/no wrong door,
- individualized,
- clinically competent, and
- accountable.[84]

Positive youth development (PYD) is a strategy for developing personal (physical, emotional, cognitive, social, and moral) competence in all children and adolescents.[85]

> *When using the PYD approach, workers focus on youth assets rather than deficits, collaborate with youth in planning the youth's future, build youth competencies rather than doing tasks for the youth, adopt a holistic perspective of healthy personal growth, and engage in long-range planning rather than short-term solutions.*[86]

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[82] Stroul, B., & Friedman, R. (1996). The system of care concept and philosophy. In B. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society* (pp. 1-22). Baltimore, MD: Paul H. Brookes Publishing Co., Inc.

[83] Stroul, B. (2002). *Issue brief—System of care: A framework for system reform in children's mental health*. Washington D.C.: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

[84] Modified from CMHS system of care principles on April 3-4, 2003

[85] Amodeo, M., & Collins, M.E. (2007). Using a positive youth development approach in addressing problem-oriented youth behavior. *Families in Society: Journal of Contemporary Social Services*, *88*(1), 75-85.

[86] Amodeo, M., & Collins, M.E. (2007). Using a positive youth development approach in addressing problem-oriented youth behavior. *Families in Society: Journal of Contemporary Social Services*, *88*(1), 75-85.

PYD is asset-based, collaborative, community-oriented, competence-building, connected (relationship focused), culturally nuanced, holistic, long-range, normative (emphasis on shared similarities with other youth), promotive (focused on pro-social activity), and universal (aimed at all youth).[87] While PYD shares much in common with the resiliency and recovery concepts, PYD is distinguished from resilience and recovery by the PYD focus on the entire universe of children and adolescents rather than just those at high risk or who are already experiencing problems.

Resilience "is the ability of individuals to remain healthy even in the presence of risk factors."[88] It can be thought of as protective shields existing at multiple levels of the ecosystem or as relational processes across these levels that bestow varying levels of immunity in the face of risk exposure.

Definitions of resilience widely differ. Some define resilience as a protective shield of traits that neutralize risk factors to yield a state of *invulnerability* or *extreme hardiness.* Others define resilience as the ability to rebound from toxic influences and traumatic experience. Some of the latter definitions use resilience and recovery interchangeably or link the two conditions.

There is growing consensus that resilience exists only in the context of adversity. Resilience is not a euphemism for health/wellness, social competence, or academic/vocational functioning—conditions often achieved in the absence of adversity. Resilience instead refers specifically to positive developmental outcomes in spite of personal and environmental risk factors.[89] Whereas the focus of PYD is on all children, resilience applies to the ability of risk-exposed children and adolescents to avoid developing problems related to those risk factors. Resilience does not apply to all children, only those exposed to risk. Put simply, without risk, there is no resilience.[90]

Resilience has been an important concept in the context of child services because it helped the field move from a "discourse of psychopathology and failure" to a discourse of potential.[91] Resilience is a valuable term applied to developmental problems of children and adolescents because it affirms a naturally positive momentum for human development. The fact is, most children experiencing childhood distress will not experience prolonged effects from such distress or will have recovered from such problems when re-evaluated at mid-life.[92] The resilience concept also brings a clear identification of risk and protective factors, optimism related to long-term developmental outcomes in spite of personal adversity, and the importance of high expectations, care

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[87] Amodeo, M., & Collins, M.E. (2007). Using a positive youth development approach in addressing problem-oriented youth behavior. *Families in Society: Journal of Contemporary Social Services*, *88*(1), 75-85.

[88] *Risk and resilience 101* (2004). National Center for Mental Health Promotion and Youth Violence Prevention. Retrieved July 30, 2009 from http://www.promoteprevent.org.

[89] Rutter, M. (2006). Implications of resilience concepts for scientific understanding. *Annals of New York Academy of Science*, *1094*, 1-12.

[90] Meschke, L.L., & Patterson, J.M. (2003). Resilience as a theoretical basis for substance abuse prevention. *Journal of Primary Prevention, 23*, 483-514. Ungar, M. (2005). A thicker description of resilience. *The International Journal of Narrative Therapy and Community Work*, *3/4*, 89-96.

[91] Ungar, M. (2005). A thicker description of resilience. *The International Journal of Narrative Therapy and Community Work*, *3/4*, 89-96.

[92] Werner, E.E. (2004). Journeys from childhood to midlife: Risk, resiliency and recovery. *Pediatrics*, *114*(2), 492.

and support, and meaningful participation within service organizations and the larger life of the community.[93]

The research on protective factors is particularly important for the design of children's services. Studies of children at risk for the development of AOD problems who did not develop such problems reveal a variety of protective shields. Theokas and Lerner[94] have conceptualized these shields in terms of personal assets (social conscience, personal values, interpersonal values and skills, risk avoidance, activity participation, positive identity, and school engagement) and ecological assets (connection to family, adult mentors, connection to community, parent involvement, connection to school, rules and boundaries, and safety) that can enhance resiliency and positive development of youth.

Trait-based protective factors include:

- cognitive skills (intelligence, attention, problem solving),[95]
- "easy temperament, a low level of emotional reactivity, and a normal level of novelty-seeking,"[96]
- social orientation (desire for and capacity to enjoy social interaction), sociability, and sustained social relationships,
- self-confidence and optimism about one's future,[97]
- pro-social values and beliefs, and
- spiritual/religious orientation.[98]

The family environment can also include protective factors that reduce risk of AOD problem development in children of an alcohol-dependent parent. These factors include:

- positive relationship with the non-alcoholic parent,[99]
- close supervision of children by the non-alcoholic parent,[100]
- quality relationship with both parents,[101]

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[93] Bernard, B. (2004). *Resilience: What we have learned.* San Francisco, WestEd.

[94] Theokas, C., & Lerner, R.M. (2005). Developmental assets and the promotion of positive development: Findings from Search Institute Data. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 27-30.

[95] Luthar, S.S. (2003). *Resilience and vulnerability: Adaptation in the context of childhood adversities.* New York: Plenum.

[96] *Resilient children of parents affected by a dependency* (2004). (Originally published as Comité Permanet de Lutte á la toxicomanie)

[97] *Resilient children of parents affected by a dependency* (2004). (Originally published as Comité Permanet de Lutte á la toxicomanie)

[98] Langehough, S.O., Walterns, C., Knox, D., & Rowley, M. (1997). *Spirituality & Religiosity as factors in adolescents' risk for anti-social behaviors and use of resilient behaviors.* Paper presented at the annual Conference of the NCFR Fatherhood and Motherhood in a Diverse and Changing World Conference, Arlington, VA.

[99] Reich, W., Earls, F., Frankel, O., & Powell, J.J. (1988). A comparison of the home and social environments of children and alcoholic and non-alcoholic parents. *British Journal of Addiction*, *83*, 831-839.

[100] Vitaro, F., Dobkin, P.L., & Zoccolillo, M. (1996). Personal and familial characteristics of resilient sons of male alcoholics. *Addiction*, *91*, 1161-1177.

- maintenance of key family rituals, e.g., family celebrations (birthdays, holidays), family traditions (vacations, reunions), and patterned routines (meals, bedtimes),[102] and
- access to social support outside the family.[103]

Finally, there are community protective factors that reduce the risk of developing AOD-related problems. Luthar[104] lists four such factors:

- access to quality education,
- participation in social/athletic activities supervised by adults,
- safe and cohesive neighborhoods, and
- access to health and social services.

Mershke and Patterson[105] reviewed the research on protective factors and drew the following conclusions:

- Protective factors are not static; they advance, are maintained, or recede as each layer of the ecosystem evolves.
- Protective factors are most important during windows of vulnerability, e.g., transition from childhood to adolescence.
- Protective factors are to resilience what recovery capital is to the long-term resolution of AOD problems.
- Protective factors increase in potency and duration of effects when combined.

Resistance has two potential meanings relevant to the current discussion: 1) an innate hardiness that allows one to be exposed to an infectious agent without becoming ill, and 2) the act of desisting or ceasing AOD use as an act of cultural or political survival.[106] The former views resistance as synonymous with resilience; the latter views abstinence as an act of personal and cultural survival in response to the perceived use of alcohol and other drugs as tools of social oppression or as a toxic balm used to ease the pain of such oppression. Resistance in this latter view is seen as critical to the process of personal, cultural, and political awakening of historically disempowered peoples. In such contexts, healing the individual, family, and community are viewed as inseparable and

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[101] Kuntsche, E., Van Der Vorst, H., & Engels, R. (2009). The earlier the more? Differences in the links between age at first drink and adolescent alcohol use and related problems according to quality of parent-child relationship. *Journal of Study of Alcohol and Drugs*, *70*, 346-354.

[102] Bennett, L.A., Wolin, S.J., & Reiss (1988). Cognitive behavioral and emotional problems among school-age children of alcoholic parents. *American Journal of Psychiatry*, *145*, 185-190. Wolin, S.J., Bennet, L.A., Noonan, D.L., & Teitelbaum, M.A. (1980). Disrupted family rituals: A factor in the intergenerational transmission of alcoholism. *Journal of Studies on Alcohol*, *41*, 199-214.

[103] *Resilient children of parents affected by a dependency* (2004). (Originally published as Comité Permanet de Lutte á la toxicomanie)

[104] Luthar, S.S. (2003). *Resilience and vulnerability: Adaptation in the context of childhood adversities.* New York: Plenum.

[105] Meschke, L.L., & Patterson, J.M. (2003). Resilience as a theoretical basis for substance abuse prevention. *Journal of Primary Prevention, 23*, 483-514.

[106] Dan D. (2008). *Resilience thinking and recovery management: Notes toward an ecological model of system transformation*. Unpublished Manuscript. Coyhis, D., & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. Colorado Springs, CO: White Bison, Inc.

require action at all of those levels.[107] Whereas resilience emphasizes latent strengths and capacities, resistance emphasizes the importance of individual and collective *consciousness* and *action.* The concept of resistance has particular salience within historically disempowered communities.[108]

Recovery from a substance use disorder has been recently defined in terms of three critical ingredients: sobriety, global health (physical, cognitive, emotional, relational, spiritual), and citizenship.[109] The term *recovery* as traditionally used applies only to those with a pre-existing disorder (there must be something to recover from) and those who meet key criteria of personal volition and durability (recovery must be voluntary and extended—measured across time via categories of early, sustained, and stable recovery). Pathways (secular, spiritual, religious) and personal styles of recovery initiation and maintenance vary considerably across individuals and cultures.[110] The concepts of *family recovery* and *community recovery* have also been applied to families and communities who repair and transcend the adverse systemic effects of severe and prolonged AOD problems.[111]

What has not been fully explored is the application of the recovery concept to youth. Because the recovery concept was developed out of a base of adult experience, its meanings and utility become less clear as one moves its application from transition age youth to adolescents to children. Even the basic dimensions of recovery must be defined in the context of youth development. For example,

- Do adolescents transitioning into adulthood who resolve severe AOD problems by decelerating AOD use to subclinical levels rather than stopping AOD use meet the "sobriety" definition of recovery? How would a "recovery-oriented" model of care view such patterns of problem resolution?
- How does the measurement of global health differ for youth than for adults? How can key developmental tasks of childhood, adolescence, and transitioning into adulthood be integrated in the "global health" component of recovery?
- How does the concept of citizenship apply to children and adolescents? What behaviors would distinguish the achievement of this dimension of recovery for children and adolescents?

Such questions have yet to be fully answered.

Recovery Management and Recovery-Oriented Systems of Care

[107] *The Red Road to Wellbriety* (2002). Colorado Springs, CO: White Bison, Inc.

[108] White, W., & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, *26*(3), 365-395.

[109] Betty Ford Institute Consensus Panel (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228. Laudet, A.B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment*, *33*, 221-228. White, W. (2007) Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229-241.

[110] White, W., & Kurtz, E. (2006). The varieties of recovery experience. International Journal of Self Help and Self Care, *3*(1-2), 21-61. White, W., & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, *26*(3), 365-395.

[111] White, W.L. (2007). A recovery revolution in Philadelphia. *Counselor, 8*(5), 34-38.

Recovery management is a philosophy of organizing addiction treatment and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery.[112] *Recovery-oriented systems of care* (ROSC) encompass the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families affected by AOD problems and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes. The "system" in this phrase is not a federal, state, or local agency, but a macro level organization of the larger cultural and community environment in which long-term recovery is nested.[113] *Systems transformation* involves planned efforts to align service concepts, service practices, and service contexts (e.g., community attitudes, funding, and regulatory policies) to support long-term addiction recovery for individuals, families, neighborhoods, and communities. ROSC rest on key principles or understandings about recovery (See Table 3) and contain key defining characteristics (See Table 4).

Table 3: Recovery-Oriented Systems of Care: Guiding Principles
1. There are many pathways to recovery.
2. Recovery is self-directed and empowering.
3. Recovery involves a personal recognition of the need for change and transformation.
4. Recovery is holistic.
5. Recovery has cultural dimensions.
6. Recovery exists on a continuum of improved health and wellness.
7. Recovery emerges from hope and gratitude.
8. Recovery involves a process of healing and self-definition.
9. Recovery involves addressing discrimination and transcending shame and stigma.
10. Recovery is supported by peers and allies.
11. Recovery involves (re)joining and (re)building a life in the community.
12. Recovery is a reality.
Source: CSAT National Summit on Recovery, September 28-29, 2007[114]

Table 4: Characteristics of a Recovery-Oriented System of Care
1. Person-centered
2. Family and other ally involvement

[112] White, W. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

[113] White, Ibid.

[114] Center for Substance Abuse Treatment. (2007). *National Summit on Recovery: Conference Report* (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration.

3. Individualized and comprehensive services across the lifespan
4. Systems anchored in the community
5. Continuity of care
6. Partnership-consultant relationships
7. Strength-based
8. Culturally responsive
9. Responsiveness to personal belief systems
10. Commitment to peer recovery support services
11. Inclusion of the voices and experiences of recovering individuals and their families
12. Integrated services
13. System-wide education and training
14. Ongoing monitoring and outreach
15. Outcomes driven
16. Research-based
17. Adequately and flexibly financed

Source: CSAT National Summit on Recovery, September 28-29, 2007[115]

CSAT's 2007 National Summit on Recovery was followed by a 2008 "Consultative Session to Design a Recovery-Oriented System of Care for Adolescents and Transition Age Youth with Substance Use Disorders or Co-Occurring Mental Health Disorders." Table 5 summarizes how participants of this meeting defined the critical characteristics of an ROSC for youth.

Table 5: Characteristics of a Recovery-Oriented System of Care for Youth
1. Family-focused/family driven
2. Age appropriate/developmental approach
3. Promotes resilience
4. Empowers youth
5. Acknowledges non-linear nature of recovery
6. Strengths-based
7. Addresses recovery capital
8. Individualized
9. Promotes hope
10. Broad array of services and supports
11. Culturally competent
12. Accessible
13. Provides choices
14. Promotes personal responsibility
15. Integrated
16. Ecological/systems perspective
17. Continuity of care
18. Engaging

[115] Center for Substance Abuse Treatment. (2007). *National Summit on Recovery: Conference Report* (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration.

19. Non-discriminatory
20. Collaborative
21. Cost-effective
22. Authenticity (honesty, integrity, fun, respect, trust, tolerance, patience)
23. Evidence-based
24. Focuses on quality of life
25. Flexible
26. Promotes accountability (outcomes)
27. Realistic
28. Statewide-level of organization

Source: Cavanaugh, Goldman, Le, & Bender, 2008[116]

Three things are striking in the comparison of Tables 3 and 4 with Table 5. First, the definition of core elements of an ROSC for adults and youth share many if not most common elements, e.g., emphasis on individualized care, family involvement, personal/family strengths, continuity of care, cultural competence, and accountability of outcomes. Second, stakeholders who defined the ideal ROSC for youth placed greater emphasis on developmentally appropriate services, resilience, empowerment/choice, and access/engagement. Third, in spite of the general call for more developmentally appropriate services in Table 5 and in the larger literature on the application of ROSC to youth, there is a striking lack of detail about what this means. There is not a clear delineation of the role of peer-based recovery support services within a youth-focused ROSC nor guidance on how to maintain peer supports over time (via peer leadership development initiatives) and how to avoid any potential iatrogenic effects of peer-based interventions. Also lacking is a clear definition of the meaning of family-focused youth services, e.g., how the developmental task of emancipation from family can be balanced with the need for sustained family support for recovery, or how concepts like empowerment and choice will be applied to children and adolescents. There is much work to be done to define a youth-focused ROSC at the level of service practice design.

Shared Characteristics of Organizing Concepts

Whereas the concepts of system of care and positive youth development were developed specifically to address concerns related to services for children and adolescents, resilience and recovery have historically been drawn from adult experience and then applied, often without adaptation, to children and adolescents. In spite of their varied pedigrees, there is considerable overlap between all of these concepts. For example, the key elements of system of care and positive youth development have much

[116] Cavanaugh. D., Goldman, S., Le, L., & Bender, C. (2008b). *Consultative session to design a recovery-oriented system of care for adolescents and transition age youth with substance use disorders or co-occurring mental health disorders*. CSAT/CMHS/SAMHSA Recovery Consultative Meeting, November 13-14, 2008.

in common with the key elements being defined as crucial to a recovery-oriented system of care.[117]

While resilience and recovery are often thought of as separate phenomenon, at least some investigators have suggested that recovery may actually be a manifestation of resilience that occurs after exposure to the adversity of addiction. This suggests the need to define resilience with a life-span trajectory and to consider the possibility that recovery may be a manifestation of a delayed form of resilience activated by some developmental turning point.[118] Resilience (in the face of extremely adverse experience) and recovery similarly share overlapping strategies: achieving both states involves identity reconstruction (who was I, what happened, who am I now—or who am I becoming), assertive approaches to emotional self-management, and forging a healthy social support network.[119]

Those who have studied recovery and resilience refer to a level of extraordinary functioning that can emerge not in spite of past risk factors but because of one's experience of having transcended such risks. White and Kurtz[120] refer to an "enriched state of recovery"—a depth of meaning and purpose, a level of functioning, and a style of service to others far superior to their pre-addiction state. Such amplified recovery occurs as an unexpected fruit of recovery for some individuals/families. This finding parallels Calhoun and Tedeschi's[121] findings that some individuals experience profoundly positive changes in the aftermath of traumatic distress. These changes include an expanded vision of life opportunities, deepening of intimate and social relationships, strengthening of personal character and coping abilities, a refocusing of priorities, and heightened experience of spirituality.[122] Rutter[123] has also explored the "steeling effect" in which experiencing adversity at one stage of life strengthens resistance to such distress at another level of life—a phenomenon suggested by the phrase "stronger at the broken places." This is analogous to people achieving heightened immunity following exposure to an infectious agent.

Rather than think of recovery and resilience in either/or terms, it may be helpful to think of systems transformation guided by both resilience and recovery. Child and family advocates in many places have embraced these concepts as complementary.[124] Figure 1 illustrates how these concepts might be viewed as linked with a total system of care and support.

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[117] Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal*, *31*(1), 38-48.

[118] Rutter, M. (2006). Implications of resilience concepts for scientific understanding. *Annals of New York Academy of Science*, *1094*, 1-12.

[119] Millar. G.M., & Stermac, L. (2000). Substance abuse and child maltreatment: Conceptualizing the recovery process. *Journal of Substance Abuse Treatment*, *19*(2), 175-182.

[120] White, W., & Kurtz, E. (2006). The varieties of recovery experience. International Journal of Self Help and Self Care, *3*(1-2), 21-61.

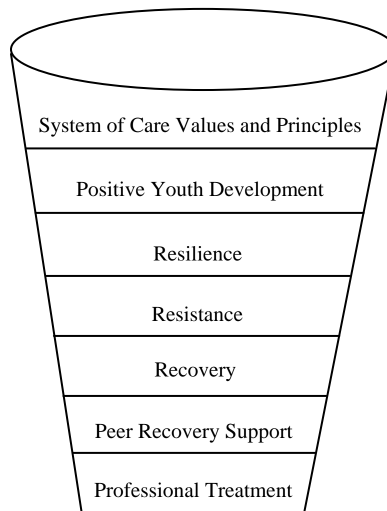
[121] Calhoun, L.G., & Tedeschi, R.G.. Eds. (2006). *Handbook of post-traumatic growth: Research and practice*. Mahwah, NJ: Erlbaum.

[122] Neimeyer, R.A. Ed. (2001). *Meaning reconstruction and the experience of loss.* Washington D.C.: American Psychological Association.

[123] Rutter, M (1981) Maternal Deprivation Reassessed, Second edition, Harmondsworth, Penguin.

[124] Walker, J.S., & Garner, T. (2005). Resilience *and* recovery: Changing perspectives and policy in Ohio. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 25-26.

Figure 1: Organizing Concepts for AOD-Related Services for Children and Adolescents



Whichever concepts are embraced, the field of children's services appears committed to casting aside pathologizing concepts and language that focus attention on "disorder and disease" and embracing new concepts and language focused on "hoping and coping."[125] The field also appears poised to reject models that define problems, resilience, and recovery as exclusively intrapersonal processes. The future lies in a focus on the ecology of resilience and recovery—placing these experiences and service strategies derived from them in their family, community, and cultural contexts.[126]

Primary Prevention, Early Intervention, Treatment, and Recovery Support

Discussions of the applicability of the recovery and resiliency concepts to children's services lead to questions about where prevention and early intervention fit into an ROSC. Prevention programs can be divided into universal approaches (targeting the general population), selective approaches (targeting groups at high risk for subsequent

[125] Ungar, M. (2005). A thicker description of resilience. *The International Journal of Narrative Therapy and Community Work*, *3/4*, 89-96.
[126] Waller, M.A., Okamoto, S.K., Miles, B.W., & Hurdle, D.E. (2003). Resiliency factors related to substance use/resistance: Perceptions of Native adolescents in the Southwest. *Journal of Sociology and Social Welfare*, *30*, 79-94.

AOD problems), and indicated approaches targeting individuals already exhibiting the emotional/behavioral precursors associated with later AOD problems.[127] Given that 1) children of parents with a history of substance use disorders are among those at highest risk for developing such disorders, 2) the recovery of the parent increases the child's resistance to and potential recovery from a substance use disorder, and 3) at risk children of parents in treatment can be identified and targeted for prevention and early intervention strategies, there is a clear link between addiction treatment and recovery support for the parent and strategies of prevention and early intervention with their at risk or substance-using children. Put simply, addiction treatment and recovery support services for parents constitute a strategy of prevention for their children. These strategies can be further amplified by involving children in the treatment of their parent and by providing specialized services designed to enhance the child's recovery from the developmental insults of parental addiction and to enhance the child's future resilience and resistance related to AOD-related problems.

The pool of people currently experiencing substance use disorders is not static, but a dynamic ever-changing population. Entry into this pool progressively draws from five groups:

1. individuals in recovery from AOD problems who remain at risk for returning to AOD use and its concomitant problems,
2. AOD consumers who are experiencing subclinical problems (not yet meeting diagnostic criteria for a substance use disorder) related to their AOD use,
3. heavy consumers of AOD as measured by frequency and quantity of use,
4. episodic and moderate but at risk AOD consumers, and
5. children, adolescents, and adults who have not yet used AOD but who are at high risk for the development of AOD problems.

Recovery-oriented systems of care must respond not just to those in acute crisis and those who need recovery maintenance support. The ideal ROSC seeks to shrink the size of all of the above populations via effective strategies of prevention and early intervention. ROSC, with its larger focus on promoting recovery-friendly communities, actually elevates the value and importance of such strategies. As an example, one could easily take the position based on the data presented in this paper that the treatment of every adult parent should include child-focused prevention and early intervention services aimed at breaking the intergenerational transmission of AOD-related problems.

Recovery Concept and Children: Advocates

Several major arguments have been set forth advocating the "added value" the recovery concept brings to service design efforts for children, adolescents, and transition age youth. These proposed advantages include the following:

[127] Gordon, R. (1987). An operation classification of disease prevention. In J.A. Steinberg, & M.M. Silberman (Eds.), *Preventing mental disorders: A research perspective* (DHHS Pub. No. (ADM) 87-1492). Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute of Mental Health.

- Recovery as an organizing concept helps shift attention from diagnosis and clinical treatment of children toward a more holistic, developmental perspective.[128]
- Recovery helps shift the focus of children's services from that of pathology, deficit inventories, and doomed prognoses to a focus on hope/optimism for each child's long-term positive development and the achievement of a meaningful and purposeful life.[129]
- Recovery adds the needed dimensions of wellness (wholeness) and spirituality—the idea that there are previously hidden powers within and outside the self that can be mobilized to promote healing, wellness, and quality of life.[130]
- Recovery emphasizes the importance of empowerment and choice.[131]
- Recovery adds new emphasis on the power of personal identity as an agent of prevention and healing: story construction/reconstruction, storytelling, and story listening.[132]
- Recovery contains the potential to move beyond symptom reduction to the potential to thrive: transcending illness/trauma in ways that render one a better person and bestow a fuller and more meaningful life than existed before,[133] e.g., recovery offering new competencies, unexpected opportunities, deeper

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[128] Theokas, C., & Lerner, R.M. (2005). Developmental assets and the promotion of positive development: Findings from Search Institute Data. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 27-30.

[129] Friesen, B.J. (2005). The concept of recovery: "value added" for the children's mental health field? *Focal Point: Research, Policy and Practices in Children's Mental Health, 19*(1), 5-8. Oswald, D.P. (2006). Recovery and child mental health services. *Journal of Child and Family Studies*, *15*, 525-527. Walker, J.S., & Freisen, B.J. (2005). Resilience and recovery: Findings from the Kauai longitudinal study. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 3-4. White, W.L., Laudet, A.B., & Becker, J.B. (2006). Life meaning and purpose in addiction recovery. *Addiction Professional, 4*(4), 18-23.

[130] Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, *31*(1), 9-22.

[131] Langehough, S.O., Walterns, C., Knox, D., & Rowley, M. (1997). *Spirituality and Religiosity as factors in adolescents' risk for anti-social behaviors and use of resilient behaviors.* Paper presented at the annual Conference of the NCFR Fatherhood and Motherhood in a Diverse and Changing World Conference, Arlington, VA. Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, *31*(1), 9-22; White, W. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services

[132] Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, *31*(1), 9-22; White, W. (1996). *Pathways from the Culture of Addiction to the Culture of Recovery*. Center City, MN: Hazelden.

[133] Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, *31*(1), 9-22. White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care, 3*(1-2), 21-61.

relationships, greater compassion, reordered personal priorities, and deepened spirituality.[134]

- The recovery concept is very congruent with the *positive youth development* (PYD) movement and "system of care" values and principles that have guided the design of child services since the 1980s.[135]
- The idea of "parallel process" within the ROSC literature acknowledges systems failures within the professional treatment of adolescent substance use and mental health disorders and the need for a recovery process for systems of care as well as individuals and families.[136]
- Recovery as an organizing concept brings needed elements not traditionally included in child and adolescent services, e.g., understandings of historical trauma and social stigma and the emphasis on treating/healing the environment.[137]
- The recovery management model promises needed continuity of support over time to the child/family and offers an alternative to the sense of abandonment that often accompanies acute care models of adolescent intervention,[138] but care must be taken not to indiscriminately apply a "chronic care" model to adolescents—many of whom will experience acute, transient AOD problems. Such misapplication could have significant iatrogenic (harm in the name of help) effects.[139]
- Integrating the ideas of recovery and resilience "draws attention to the importance of connectedness as a developmental asset for all youth."[140]
- Using recovery as an organizing concept for children's services provides impetus for the involvement of primary care physicians in the assessment and early intervention into child and adolescent AOD problems.[141]
- The focus on the role contextual factors play in the development and resolution of adolescent substance use disorders (e.g, the influence of AOD availability, AOD peer group norms, AOD-related laws and institutional

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[134] Walsh, F. (2007). Traumatic loss and major disasters: Strengthening family and community resilience. *Family Process*, *46*(2), 207-227.

[135] Eccles, J.S., & Gootman, J.A. (Eds.) (2002). *Community programs to promote youth development*. Washington D.C.: National Academy Press. Huffine, C. (2005). Supporting recovery for older children and adolescents. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 22-23.

[136] Lamb, R., Evans, A.C., & White, W. (2009) *The role of pPartnership in recovery-oriented systems of care: The Philadelphia experience.* Unpublished Manuscript. Oswald, D.P. (2006). Recovery and child mental health services. *Journal of Child and Family Studies, 15*, 525-527.

[137] Friesen, B.J. (2005). The concept of recovery: "value added" for the children's mental health field? *Focal Point: Research, Policy and Practices in Children's Mental Health, 19*(1), 5-8.

[138] White, W., Dennis, M., & Godley, M. (2002). Adolescent substance use disorders: From acute treatment to recovery management. *Reclaiming Children and Youth, 11*(3), 172-175.

[139] White, W., Boyle, M., & Loveland, D. (2003). Addiction as chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly, 20,* 107-130.

[140] Walker, J.S., & Freisen, B.J. (2005). Resilience and recovery: Findings from the Kauai longitudinal study. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 3-4.

[141] Knight, J.R. (2001). The role of primary care provider in preventing and treating alcohol problems in adolescence. *Ambulatory Pediatrics*, *1*(3), 150-161.

policies, alcohol advertising, etc.) may sharpen our examination of how these same factors influence adult AOD problems and their resolution.[142]

Recovery Concept and Children: Critics

The major arguments against applying the recovery concept to children, adolescent, and transition age youth services include the following:

- The recovery concept (and other "re" words—*reform*, *redeem*, *rebirth*, *regeneration*, *rehabilitation*—applied to the resolution of severe and prolonged AOD problems) implies return to a previous state of health and functioning rather than the forward developmental trajectory through childhood and adolescence into adulthood; recovery is an adult concept misapplied to children.[143] (Youth-focused recovery models counter this by incorporating the concept of *discovery* into their recovery concept and reinterpreting the meaning of recovery across the life cycle.)
- The term *recovery* is not well understood by stakeholder groups within the child and adolescent service arena; some like the idea of recovery (its hope and optimism), but do not like the word.[144] This is an example of how stigma could lead to the rejection of recovery as an organizing concept.
- The recovery concept fails to "draw attention to some of the issues that are particularly important for children and families."[145]
- The term *recovery* implies a medicalized disease orientation that lacks the developmental perspective critical to children's services.[146]
- The recovery concept, with its focus on the resolution of a particular illness or problem, inhibits a more holistic understanding of the child/family's assets, needs, and aspirations.[147]

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[142] Hawkins, J.D., Catalano, R.F., & Miller, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin*, *112*, 64-105.

[143] Theokas, C., & Lerner, R.M. (2005). Developmental assets and the promotion of positive development: Findings from Search Institute Data. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 27-30. Walker, J.S. & Garner, T. (2005). Resilience *and* recovery: Changing perspectives and policy in Ohio. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 25-26.

[144] Walker, J.S., & Freisen, B.J. (2005). Resilience and recovery: Findings from the Kauai longitudinal study. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 3-4.

[145] Walker, J.S. & Garner, T. (2005). Resilience *and* recovery: Changing perspectives and policy in Ohio. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 25-26.

[146] Friesen, B.J. (2005). The concept of recovery: "value added" for the children's mental health field? *Focal Point: Research, Policy and Practices in Children's Mental Health, 19*(1), 5-8. Theokas, C., & Lerner, R.M. (2005). Developmental assets and the promotion of positive development: Findings from Search Institute Data. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 27-30. Walker, J.S. & Garner, T. (2005). Resilience *and* recovery: Changing perspectives and policy in Ohio. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 25-26.

[147] Theokas, C., & Lerner, R.M. (2005). Developmental assets and the promotion of positive development: Findings from Search Institute Data. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 27-30.

- Recovery—with its reversal of illness focus—is not appropriate as a conceptual framework for organizing services for young children, but may offer some advantages in the organization of services for adolescents.[148]
- Much of what is called for in recovery-focused systems transformation efforts has already been emphasized in "system of care" models of children's services, e.g., "comprehensive, coordinated, community-based, individualized, culturally competent, child centered and family focused."[149]
- The recovery model's emphasis on self-determination, empowerment, choice, and personal responsibility is inappropriate at worst and at best, difficult to apply to children.[150]
- Many aspects of the recovery concept and recovery-related service practices must be significantly adapted to fit the developmental stages of the adolescent and the developmental stages of adolescent recovery.[151]
- The term *recovery* may set unrealistic and universal expectations of "full cure" for children with severe behavioral health problems.[152] Conveying expectations of "full cure" may also be inappropriate within systems of care that also provide services for children and adolescents with severe developmental disabilities.
- The term *recovery* carries social stigma attached to addiction that should not be indiscriminately applied to children's services.[153] The term *recovery* has been rejected in other arenas in favor of *resilience* on the grounds that recovery carries "negative surplus meaning"—a professional euphemism for the stigma attached to severe substance use and other psychiatric disorders.[154]
- The term *recovery* brings added value but is not inclusive enough; combining these concepts via the phrase *resilience and recovery* best captures the conceptual elements critical to the needed transformation in children's mental health services.[155]

Debate over the application of recovery to the C & A service arena is handicapped by recovery advocates who are not knowledgeable about prevailing concepts in the C &

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[148] Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal*, *31*(1), 38-48.

[149] Friesen, B.J. (2005). The concept of recovery: "value added" for the children's mental health field? *Focal Point: Research, Policy and Practices in Children's Mental Health, 19*(1), 5-8.

[150] Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal*, *31*(1), 38-48.

[151] Blumberg, D. (2004). Stage model of recovery for chemically dependent adolescents: Part 1—methods and models. *Journal of Psychoactive Drugs*, *36*(3), 323-345. Blumberg, D. (2005). Stage model of recovery for chemically dependent adolescents: Part 2—Model evaluation and treatment implications. *Journal of Psychoactive Drugs*, *37*(1), 15-25.

[152] Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal*, *31*(1), 38-48.

[153] Oswald, D.P. (2006). Recovery and child mental health services. *Journal of Child and Family Studies*, *15*, 525-527.

[154] Sandler, I.N., Wolchik, S.A., & Ayers, T.S. (2008). Resilience rather than recovery: A contextual framework on adaptation following bereavement. *Death Studies*, *32*, 59-73.

[155] Walker, J.S. & Garner, T. (2005). Resilience *and* recovery: Changing perspectives and policy in Ohio. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 25-26.

A service arena and child advocates who are unfamiliar with the efforts to nuance the recovery concept within a developmental perspective. Debates over ideas and language from both sides may mask issues of personal, professional, and organizational status and power. Put simply, these discussions can sometimes tap very primitive interests and emotions.

The Philadelphia Focus Groups

The Philadelphia Department of Behavioral Health and Mental Retardation Services conducted a series of focus groups during the summer of 2008 to discuss several basic questions related to the application of the concept of recovery to children and adolescent services and to define core characteristics of an ROSC for children and adolescents. Separate focus groups were hosted for service providers, parents, family members, and representatives from the Youth Leadership Council.

Focus group participants expressed support for blending the concepts of resilience and recovery as an organizing framework for youth services, with the caveat that communicating the definitions of and relationship between these two terms throughout the behavioral health care system would enhance clarity of service planning and the quality of service practices. Common domains of activity/focus were defined that were shared by both the recovery and resiliency concepts and that needed definition and refinement in the context of children's services. These domains included:

- developmentally-informed models of care,
- family inclusion/direction and leadership,
- peer support and leadership,
- continuum of support (versus continuum of care), e.g., support that includes but transcends professional treatment and embraces prevention activities,
- community integration and mobilization of community recovery/resiliency support resources,
- trauma-informed care (and addressing violence within the trauma framework), and
- culturally competent care.

One of the priorities expressed in the focus groups was the need for models and mechanisms of family partnership/leadership and family-focused programming. Potential strategies discussed included:

- youth advisory boards/family advisory councils,
- family representation on policy boards,
- development of grassroots family advocacy organizations,
- new strategies of family assessment and engagement,
- formal family orientation/education programs,
- use of family advocates by treatment organizations,
- family-inclusive treatment,
- family support groups,
- family-focused alumni activities,
- parenting education groups/classes,

- development of clinical and family peer recovery support service options for family members (children and siblings in particular) of all persons admitted for addiction treatment, and
- development of new family peer support programs.

A group of youth much discussed in the Philadelphia focus groups was transition age youth who were "aging out" of the child service system with little transitional support when they were no longer eligible to continue receiving services. It was hoped that new approaches to such transition planning could be developed given the ROSC emphasis on long-term, stage-appropriate recovery support.

The Voices of Youth

Before outlining recommendations based on this review, we thought it appropriate to give the final words of input of the 16 youth who participated in recent focus groups in Philadelphia. Here were some of the sentiments expressed by those young people.

> *Understand me, don't force things on me, don't have pre-judgments/assumptions based on what you read about me. Learn to know me and take a fresh approach.*
>
> *Don't use the chart except to know the worst thing I am capable of.*
>
> *Try to get to know me. Connect with me on a personal level. Get to understand my point of view. Ask me relaxed questions, don't drill me. Ask me "what is going on in your life right now?"*
>
> *Don't have my family involved unless it is okay with me.*
>
> *List the positive stuff about me that you see; that helps me to open up. Look for the talents I have as a person, sometimes you might figure it out before me. Build a base with me (of relationship), I can tell a lot about you from your face, from your tone of voice.*
>
> *Tell me something about yourself. If I know anything about you beyond what degrees you have, it helps me to open up. But don't tell me too much about yourself. I had a therapist who told me all her troubles, that wasn't why I was there.*
>
> *Don't use words I don't understand…I am already scared, make me feel safe.*
>
> *Be a human being I can connect with; don't use stuff out of books.*
>
> *Don't blow things out of proportion, just because I make a mistake doesn't mean I am oppositional or sick, it just means I made a mistake.*

Don't diagnose me without cause just because I have to have a diagnosis to get funding, and don't medicate things that can be talked out.

A peer counselor would help because you can't trust school counselors. Except for one who helped set up a peer group at school with kids who were going through the same thing as me. That helped me a lot.

There is so much violence in the community it isn't safe to be connected there.

I disagree. I think we need to be connected to good things that are going on in the community.

You go where you get respect and feel powerful, and that may be a gang in the community.

I had nowhere to go, nothing to do but then someone sent me to the PAL center. There were activities there and adults (mostly cops) to relate to. Therapists need to know these resources.

Summary and Recommendations

So what are the "take home" messages from this sweeping discussion of the use of recovery as an organizing concept for children and adolescent services and the role of such services within efforts to transform addiction treatment and the larger communities in which treatment is imbedded into recovery-oriented systems of care? Several points seem critical:

- A recovery-focused transformation in behavioral healthcare is underway in the United States and other countries, but the implications of such transformation processes on child and adolescent (C & A) services have not been fully defined.
- Recovery offers "added value" as an organizing concept for C & A services, but its greatest potential within the C & A service arena lies in its integration with the concepts of resilience and resistance.
- Recovery as an organizing concept has multiple applications to the C & A service arena:
    1. the achievement of sobriety, global health, and citizenship by children, adolescents, and transition age youth experiencing a substance use disorder,
    2. reversing the developmental insults experienced by children and adolescents who have been exposed to the addiction of a parent or sibling, and
    3. reducing the risks of intergenerational transmission of AOD problems.
- The concept of recovery has particular utility within the C & A services arena in light of the lowered age of onset of AOD use and the increased prevalence of adolescent substance use disorders.

- Treatment resources for adolescent substance use disorders have increased dramatically in the United States, but brief biopsychosocial stabilization is often followed by resumption of AOD use and its concomitant problems. Efforts are needed to extend acute treatment to sustained, post-treatment recovery support.
- *Recovery management* as a philosophy of treatment has much to offer adolescents and transition age youth with severe and complex AOD problems but could generate iatrogenic effects (harm in the name of help) if indiscriminately applied to all AOD-using youth.
- The emerging conceptualization of the core elements of a *recovery-oriented system of care* (ROSC) for children, adolescents, and transition age youth has much in common with earlier organizing frameworks (e.g., system of care and positive youth development) for children and adolescent services.
- It is crucial that a youth-focused ROSC reflect the full integration of primary prevention, early intervention, clinical treatment, and non-clinical recovery support services.
- Arguments for and against the use of recovery as an organizing construct for C & A services are not mutually exclusive. Strategies should be developed that capitalize on the positive additions recovery brings to C & A services and that minimize untoward effects that the application of this concept could generate within C & A services.
- There is growing consensus that an ROSC for C & A should be designed to:

    1. Assure youth and parent involvement in the planning, design, conduct, and evaluation of prevention, early intervention, treatment, and post-treatment recovery support services.
    2. Instill traits and experiences known to serve as protective factors (competence, confidence, attachment, flexibility, opportunity).
    3. Enhance parenting skills, elevate supervision patterns, and re-establish/strengthen family rituals of adults and their partners being treated for a behavioral health disorder.[156]
    4. Reduce family, neighborhood, and community stressors.
    5. Promote "positive chain reactions"—saturated support, guidance, and multiple opportunities during periods of elevated risk.[157]
    6. Provide access to family counseling and counseling for the children and adolescents of adults undergoing addiction treatment. Sankaran[158] advocated that all addiction treatment programs include programs for families and children that focused on improved parenting and equipping children with specific skills (self-esteem, coping, conflict resolution, and assertiveness) to enhance resilience.

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[156] Sankaran, L., Muralidhar, D., & Benegal, V. (2006). *Strengthening resilience with families in addiction treatment*. Unpublished Paper.

[157] Rutter, M. (2005). Natural experiments, casual influences, and policy development. In M. Rutter, & M. Tienda (Eds), *Ethnic variations in intergenerational continuities and discontinuities in psychosocial features and disorders*. New York & London: Cambridge University Press.

[158] Sankaran, L., Muralidhar, D., & Benegal, V. (2006). *Strengthening resilience with families in addiction treatment*. Unpublished Paper.

7. Provide youth-to-youth and parent-to-parent peer-based recovery support services.[159]
8. Assure AOD-involved children and adolescents a continuum of support that spans pre-recovery identification and engagement, recovery initiation and stabilization, recovery maintenance, and enhanced quality of personal/family life in long-term recovery.[160]
9. Provide assertive approaches to continuing support following specialized addiction treatment.[161]
10. Assure transitional supports for youth who are aging out of the child service system.

The following recommendations are offered as points for continued discussion as the City of Philadelphia continues its behavioral health care systems transformation process and seeks to fully involve C & A services within that transformation process.

The Concepts and Language of Systems Transformation

1. Expand the Language of Systems Transformation. The phrase "supporting recovery, building resilience, and enhancing self-determination" ("recovery, resilience, and self-determination" for short) to describe systems transformation efforts offers a means of bridging the three DBH/MRS service arenas (addiction, mental health, and developmental disabilities) and a framework for integrating primary prevention, early intervention, treatment, and non-clinical recovery support services. Discussions of the common and distinguishing features of positive recovery, resilience, resistance, youth development, and systems of care may enhance our capacity to "develop complex, ecologically-based interventions that address the child in the context of family and community."[162]
2. Elevate Asset-Focused Language. Services for children, adolescents, and transition age youth should focus on strengths of individuals, families, and communities. Elevating the concepts of *recovery*, *resiliency*, *protective factors,* and *recovery capital* within DBH/MRS could underscore this emphasis on personal, family, and community assets.
3. Explicitly Define "Youth." Conduct all discussions of youth service needs within a framework that distinguishes the differences in these needs for children, adolescents, and transition age youth.

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[159] *Blamed and ashamed.* (2001). Alexandria, VA: Federation of Families for Children's Mental Health.
[160] White, W. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services
[161] Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, *23*, 21-32. Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2006). The effect of assertive continuing care on continuing care linkage, adherence, and abstinence following residential treatment for adolescent substance use disorders. *Addiction*, *102*, 81-93.
[162] Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal*, *31*(1), 38-48.

Representation and Leadership

1. Model Representation/Leadership within DBH/MRS. Designate positions within the Office of Addiction Services Advisory Board for youth and family representation.
    - Recruit youth and family members for inclusion in key DBH/MRS leadership development activities, e.g., Peer Group Facilitation Training, Recovery Foundations Training, Peer Leadership Academy, and Storytelling Training.
    - Designate leadership positions on Advisory Boards for youth and family representation.
    - Involve youth and family members in planning the redesign of the service system.
    - Facilitate ways for youth and family members to participate in critical evaluation tasks such as conducting focus groups with peers, assisting with the development of satisfaction surveys, etc.
    - Develop separate youth and family advisory councils that have direct access to the leadership within the system.
    - Create expectations for youth and family leadership within provider agencies and align monitoring processes to assess provider compliance.
    - Involve transition age youth and families in the monitoring of services.

2. Encourage Representation/Leadership in Behavioral Health Care Network via dissemination of papers on best practices and provision of technical assistance.

Recovery Visibility of Youth

1. Establish and Monitor Youth Recovery Prevalence. Conduct, evaluate, and publicly disseminate recovery prevalence survey data (household and school surveys) for youth 18 years of age or younger. (Work with existing surveys to assure inclusion of questions that allow reporting of youth recovery prevalence.)
2. Encourage and support a vanguard of recovering young people whose life circumstances allow and who are called to put a face and voice on recovery among young people.

Collaboration and Partnership

1. Work with Mayor's Blue Ribbon Commission on Children's Behavioral Health and the Office of Addiction Services to integrate the concepts of resilience and recovery at planning and service practice levels.

Develop a Continuum of (Personal/Family/Community) Recovery Support

1. Replace the concept of "continuum of care" with "continuum of support" to provide a broader conceptual umbrella to integrate primary prevention, early

intervention, clinical treatment, non-clinical recovery support services, recovery community building activities, and advocacy of policies aimed at enhancing the resilience and recovery of children and adolescents.

2. Explore ways to nest the process of recovery and wellness in young people's natural environments rather than focusing solely on how to get youth with AOD-related problems into treatment. These strategies might include:
   - partnerships with athletic clubs, neighborhood groups, recreation centers, libraries, faith communities, local shopping centers to conduct prevention activities, outreach, early identification/intervention,
   - conducting youth-focused surveys of community recovery capital (Mapping AOD problems indicator data for youth, youth-focused treatment, and recovery support resources by zip code to identify areas of unmet service needs, to evaluate the effects of neighborhood-targeted service projects, and to identify areas in the community that need additional recovery supports), and
   - exploring how indigenous community resources can be used to extend post-treatment support for youth and families from a few weeks or months to the years spanning the transition from adolescence into young adulthood.

3. Support expanded prevention and early intervention strategies, particularly among high risk youth to prevent or postpone use of intoxicants. This would entail:
   - forging partnerships with schools, faith community, etc. to raise awareness and increase community level resources (protective factors/recovery capital) that can enhance the health of at risk and recovering youth, and
   - lowering the threshold of engagement for substance-involved youth, e.g., viewing motivation as a service/support outcome rather than a requirement for service/support initiation and shifting from confrontational to motivational methods of engagement and support.

4. Utilize an expanded continuum of support model with adolescents and transition age youth with severe and complex AOD problems**.** Explore the use of recovery check-ups (post-treatment monitoring and support) and formal systems of peer-based recovery coaching for adolescents with severe and prolonged AOD problems—saturating such support in the first 90 days following primary treatment.[163]

Practice Guidelines

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[163] Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, *23*, 21-32. Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2006). The effect of assertive continuing care on continuing care linkage, adherence, and abstinence following residential treatment for adolescent substance use disorders. *Addiction*, *102*, 81-93.

1. Develop distinct recovery/resiliency-oriented practice guidelines for children/adolescents within all practice guideline documents.
2. Explore development of a wide range of youth-to-youth and parent-to-parent peer recovery support services, including family-to-family outreach.[164]

Assessment and Treatment/Recovery Planning

1. Encourage the use of global screening and assessment procedures that address multiple youth and family life domains, as opposed to problem-specific approaches.
2. Encourage holistic approaches to adolescent care and support, e.g., multidisciplinary and multi-agency intervention models that can provide an integrated response to youth and families experiencing multiple challenges.
3. Encourage the transition from professionally-directed treatment plans to personalized, family- and youth-directed recovery plans.[165]
4. Ensure that treatment services are linked to meaningful goals/desires/activities for each young person.
5. Focus on development of service plans that build competencies in multiple domains (social, emotional, cognitive, etc.) rather than focus only on the remediation of deficits or problem behaviors.

Recovery-Focused Treatment

1. Provide youth and families experiencing AOD-related problems access to evidence-based models of treatment, including family-focused approaches to treatment.
2. Provide family-focused education, professional and peer-based recovery coaching, and continuing care support groups.
3. Provide advocates to help families navigate increasingly complex service systems.
4. Enhance parenting skills, elevate supervision patterns, and re-establish/refine/strengthen family rules and rituals.

Develop a Youth/Family-Focused Peer Recovery Culture

1. Explore the development of a wide range of youth-to-youth and parent-to-parent peer recovery support services, including family-to-family outreach.[166]

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[164] Smith, S.L., Hornberger, S., Brewington-Carr, S. Finck, C., O'Neill, C., Cavanaugh, D., & Bender, C. (2009). Family involvement in adolescents substance abuse treatment. *Improving Access to and Quality of Treatment for Adolescents with Substance Use/Co-Occurring Mental Health Disorders*. *1*(1), 1-7.

[165] Borkman, T. (1998). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment*, *15*(1), 37-42.

[166] Smith, S.L., Hornberger, S., Brewington-Carr, S. Finck, C., O'Neill, C., Cavanaugh, D., & Bender, C. (2009). Family involvement in adolescents substance abuse treatment. *Improving Access to and Quality of Treatment for Adolescents with Substance Use/Co-Occurring Mental Health Disorders*. *1*(1), 1-7.

2. Work with local service committees of recovery mutual aid fellowships to expand the availability of young people's recovery support meetings and persons willing to sponsor young people entering recovery.
3. Utilize assertive linkage procedures between adolescent treatment and local recovery support groups.[167]
4. Explore such peer to peer services as:
    - peer-based adolescent outreach and engagement efforts that are based in natural support settings such as schools, places of worship, community recreation centers, etc.,
    - adolescent and family peer-facilitated support and education groups within treatment settings, particularly within residential treatment facilities,
    - peer-to-peer continuing support services available to youth and families to help sustain the gains made in the treatment context,
    - technology-based peer support strategies that leverage the growing centrality of technology within the daily lifestyle of adolescents, e.g., the use of social networking websites and text messaging for peer support and recovery coaching,
    - adolescents should be engaged in determining what kinds of peer support activities and roles would be helpful in the system, and how these supports might be structured to maximize utilization,
    - web-based peer supports designed to educate and support families, and
    - recruitment and training of younger staff (and young people in recovery) to work with youth.

Evaluate Effects of Systems Transformation on C & A Services

1. Provide a Quality of Care Report Card for the major DBH/MRS-funded C & A service providers.
2. Assure the inclusion of parents and siblings affected by youth substance use disorders and youth in recovery from such disorders in the planning, design, conduct, and evaluation of substance-related services for youth.[168]
3. Conduct a youth-focused survey of community recovery capital. Map AOD problems indicator data for youth-focused treatment and recovery support resources by zip code to identify areas of unmet service needs and to evaluate the effects of neighborhood-targeted service projects.

These recommendations, though grounded in the scientific literature and the growing body of experiential knowledge in the City of Philadelphia, constitute a starting point for continued discussion.

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[167] Passetti, L. L., & Godley, S. H. (2008). Adolescent substance abuse treatment clinicians' self-help meeting referral practices and adolescent attendance rates. *Journal of Psychoactive Drugs, 40*, 29-40.

[168] Smith, S.L., Hornberger, S., Brewington-Carr, S. Finck, C., O'Neill, C., Cavanaugh, D., & Bender, C. (2009). Family involvement in adolescents substance abuse treatment. *Improving Access to and Quality of Treatment for Adolescents with Substance Use/Co-Occurring Mental Health Disorders*. *1*(1), 1-7.

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Appendix A: Definitions of Addiction Recovery

Recovery is "overcoming both physical and psychological dependence to a psychoactive drug while making a commitment to sobriety."[169]

"Recovery is the experience of a meaningful, productive life within the limits imposed by a history of addiction to alcohol and/or other drugs. Recovery is both the acceptance and transcendence of limitation."[170]

Recovery is "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles."[171]

Recovery means that someone is "trying to stop using alcohol or drugs."[172]

"The term *Wellbriety* is an affirmation that recovery is more than the removal of alcohol and other drugs from an otherwise unchanged life. Wellbriety is a larger change in personal identity and values and a visible change in one's relationship with others. It is about physical, emotional, spiritual, and relational health. Wellbriety is founded on the recognition that we cannot bring one part of our lives under control while other parts are out of control. It is the beginning of a quest for harmony and wholeness within the self, the family and the tribe."[173]

"Recovery is the process of pursuing a fulfilling and contributing life regardless of the difficulties one has faced. It involves not only the restoration but continued enhancement of a positive identity and personally meaningful connections and roles in one's community. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members."[174]

"Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life."[175]

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[169] ASAM (2001). *Patient placement criteria for the treatment of substance use disorders* (2nd edition). Chevy Chase, MD: American Society of Addiction Medicine.

[170] White, W. (2002). *An addiction recovery glossary: The languages of American communities of recovery*. First posted at www.bhrm.org In White, W. (2006). Let's go make some history: Chronicles of the new addiction recovery advocacy movement. Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

[171] Anthony, W. A., Rogers, E. S., & Farkas, M. (2003). Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal*, *39*(2), 101-114.

[172] Peter D. Hart Research Associates (2004). *Faces and Voices of Recovery Public Survey*. Washington D.C.: Peter D. Hart Research Associates.

[173] *The red road to wellbriety.* (2002). Colorado Springs, CO: White Bison, Inc.

[174] Recovery Advisory Council, Philadelphia Department of Behavioral Health, 2005

[175] Center for Substance Abuse Treatment. (2007). *National Summit on Recovery: Conference Report*. (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration.

"Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship."[176]

"Long-term recovery is an enduring lifestyle marked by: 1) the resolution of alcohol and other drug problems, 2) the progressive achievement of global (physical, emotional, relational) health, and 3) citizenship (life meaning and purpose, self-development, social stability, social contribution, elimination of threats to public safety)."[177]

Appendix B: Definitions of Resilience

Resilience is the "ability of individuals to overcome adversity."[178]

"Resilience refers to a process of adaptation whereby individuals learn to overcome destabilizing effects resulting from traumatic experiences of greater or lesser severity."[179]

"Resilience…manifests itself as successful adaptation at the individual level, despite harmful circumstances or life events normally considered risk factors from the standpoint of adaptation."[180]

"Resilience is the ability of individuals to remain healthy even in the presence of risk factors."[181]

"Resilience is a dynamic process encompassing positive adaptation within the context of significant adversity."[182]

[176] Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*, 221-228.

[177] White, W. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services

[178] Ungar, M. (2005). A thicker description of resilience. *The International Journal of Narrative Therapy and Community Work*, *3/4*, 89-96.

[179] Resilient children of parents affected by a dependency (2004) (Originally published as Comité Permanet de Lutte á la toxicomanie).

[180] Resilient children of parents affected by a dependency (2004) (Originally published as Comité Permanet de Lutte á la toxicomanie)

[181] National Center for Mental Health Promotion and Violence Prevention. (2009). *Risk and Resilience 101*. Retrieved April 22 from http://www.promoteprevent.org.

[182] Luthar, S.S., Cichetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, *71*(3), 543-562.