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


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. The second is an effort to extend addiction treatment from models of acute biopsychosocial stabilization or palliative care to a model of active and sustained recovery management and to nest these services within larger “recovery-oriented systems of care.” 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.

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 identifies several distinguishing elements of the “Philadelphia Model” of behavioral health care systems transformation.

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

<table>
<thead>
<tr>
<th>System Dimension</th>
<th>Philadelphia Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery Vision</td>
<td>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.</td>
</tr>
<tr>
<td>Varieties of Recovery Experience</td>
<td>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.</td>
</tr>
<tr>
<td>Systems Level Recovery Management</td>
<td>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.</td>
</tr>
<tr>
<td>Behavioral Health Care Integration</td>
<td>Recovery is used as a conceptual bridge for the increased integration of professionally-directed mental health services, professionally-directed addiction treatment services, peer-based recovery support services, and primary health care.</td>
</tr>
<tr>
<td>Systems Integration</td>
<td>Federal, state, county, and municipal resources are coordinated to generate increased resources, strategically allocate resources, and provide regulatory relief.</td>
</tr>
<tr>
<td>Service Accessibility</td>
<td>Service entry is accessible, efficient, respectful, and warmly welcoming: all system elements are devoted to the goal of rapid and gracious service engagement.</td>
</tr>
<tr>
<td>Global Assessment</td>
<td>Assessment is comprehensive, strengths-based, continual, family-inclusive, and encompasses assessment of each client’s recovery environment.</td>
</tr>
<tr>
<td>Service Quality and Responsiveness</td>
<td>Services are developmentally appropriate, gender-specific, culturally competent, trauma-informed, family-focused, and evidence-based.</td>
</tr>
<tr>
<td>Indigenous</td>
<td>Services at all levels of care include assertive linkage to</td>
</tr>
</tbody>
</table>
Resources

| Resources | 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

| 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

| 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

| 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.

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.

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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.¹⁰

Those readers with any significant tenure in health and human service systems will have witnessed the rise and fall of many newly proclaimed

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organizing concepts. Seen in this historical context, it is difficult to
determine whether an emerging concept adds something fundamentally new
and valuable or whether it represents a repackaging of old ideas into a new
rhetoric. Huffine 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?

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?

An effective organizing concept—what Room 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”. 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

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Academy of Science*, 1094, 1-12.
September, 2-4.
12 Philadelphia Caregiver Focus Group Participant, 2009
13 Philadelphia Caregiver Focus Group Participant, 2009
15 Alcoholics Anonymous (1939). Proposal to form the One Hundred Men Corporation to publish the book
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.\textsuperscript{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 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.\textsuperscript{17} As the

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\textsuperscript{17} See http://www.dhmb.rs/assets/Forms--Documents/4.2.1.2-OAS-Goals-Objectives-Board-Final-Draft-20080620.pdf
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

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.\textsuperscript{20} To add specificity to the coming discussions, we will apply these concepts and principles to three distinct developmental groups: \emph{children}, \emph{adolescents}, and \emph{transition age-youth} (also referred to as \emph{emerging adults}).\textsuperscript{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,\textsuperscript{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.\textsuperscript{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.\textsuperscript{24} By the early 1990s, more than one third of drug-using youth incarcerated within state-operated juvenile facilities reported onset of drug use before age 12 (19\% before age 10).\textsuperscript{25} A 2005 study of children in foster care found that more than one-third of older children met diagnostic criteria for a substance


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use disorder.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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,\textsuperscript{30}
- increased risk of developing a substance use disorder,\textsuperscript{31}


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

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

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.  

In a recent analysis of 14,776 adolescent addiction treatment admissions, Dennis, White, and Ives 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.  

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.  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

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adolescents and families feeling abandoned at discharge. 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.

Family Recovery

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.

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. 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. Children may also be negatively affected by exposure to sibling substance use, e.g., increased risk of early substance experimentation and subsequent problem development. 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. This risk can be ameliorated by involving siblings in the treatment of their brother or sister.

**Childhood Risk and Resilience:** Most children and adolescents rebound from the effects of an adverse childhood environment. Most (60-75%) children of alcohol-dependent parents will not go on to develop AOD problems, 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.

- There is a clear but complex relationship between parental addiction, neglect, and maltreatment of children and the subsequent emotional and behavioral health of children.
- Children, particularly male children, of alcohol/drug-dependent parents are at increased risk of developing these same problems as well as other developmental problems.

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• 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.\textsuperscript{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.\textsuperscript{57}

• 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.\textsuperscript{58}

Parental Recovery and Child Development: Key aspects of family life disrupted by addiction continue to be disrupted during the early years of recovery.\textsuperscript{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. 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. 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. 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.

“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.” Multiple studies confirm the improved health of the children of a substance-dependent parent who enters and sustains a recovery process. The chain of 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. 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

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their families that could be integrated into mainstream addiction treatment. 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,” 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. 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. 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. The profile of transition age youth most in need of treatment is that of a young adult male

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

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

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 Services74 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 youth76 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 review78 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 functioning in the family, school, and community) and reduced substance use (to approximately 50% of pretreatment 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. 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.

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.

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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 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

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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.\(^{86}\)

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.

\(^{84}\) Modified from CMHS system of care principles on April 3-4, 2003
Resilience “is the ability of individuals to remain healthy even in the presence of risk factors.”\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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 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 Lerner94 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

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96 Resilient children of parents affected by a dependency (2004). (Originally published as Comité Permanet de Lutte à la toxicomanie)
97 Resilient children of parents affected by a dependency (2004). (Originally published as Comité Permanet de Lutte à la toxicomanie)
- close supervision of children by the non-alcoholic parent,\textsuperscript{100}
- quality relationship with both parents,\textsuperscript{101}
- maintenance of key family rituals, e.g., family celebrations (birthdays, holidays), family traditions (vacations, reunions), and patterned routines (meals, bedtimes),\textsuperscript{102} and
- access to social support outside the family.\textsuperscript{103}

Finally, there are community protective factors that reduce the risk of developing AOD-related problems. Luthar\textsuperscript{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\textsuperscript{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.


\textsuperscript{103}Resilient children of parents affected by a dependency (2004). (Originally published as Comité Permanet de Lutte à la toxicomanie)


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. 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 require action at all of those levels. 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.

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. 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. The concepts of family recovery and community recovery have also been applied to families and communities who repair and

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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

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

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larger cultural and community environment in which long-term recovery is nested.\textsuperscript{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).

\begin{table}[h]
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\begin{tabular}{|l|}
\hline
Table 3: Recovery-Oriented Systems of Care: Guiding Principles \\
\hline
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. \\
\hline
Source: CSAT National Summit on Recovery, September 28-29, 2007\textsuperscript{114} \\
\end{tabular}
\end{table}

\begin{table}[h]
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\hline
Table 4: Characteristics of a Recovery-Oriented System of Care \\
\hline
1. Person-centered \\
2. Family and other ally involvement \\
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 \\
\hline
\end{tabular}
\end{table}

\textsuperscript{113} White, Ibid. \\
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

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  
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\textsuperscript{116}

...
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 in common with the key elements being defined as crucial to a recovery-oriented system of care.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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\textsuperscript{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\textsuperscript{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. Rutter 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. Figure 1 illustrates how these concepts might be viewed as linked with a total system of care and support.

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

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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.” 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.

**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 AOD problems), and indicated approaches targeting individuals already exhibiting the emotional/behavioral precursors associated with later AOD problems. 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

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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:
• Recovery as an organizing concept helps shift attention from diagnosis and clinical treatment of children toward a more holistic, developmental perspective.\textsuperscript{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.\textsuperscript{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.\textsuperscript{130}

• Recovery emphasizes the importance of empowerment and choice.\textsuperscript{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.\textsuperscript{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, recovery offering new competencies, unexpected opportunities, deeper relationships, greater compassion, reordered personal priorities, and deepened spirituality. 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.

- 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.

- 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.

- 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, 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.


Integrating the ideas of recovery and resilience “draws attention to the importance of connectedness as a developmental asset for all youth.”

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.

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

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. (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

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recovery (its hope and optimism), but do not like the word. 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.”
- The term recovery implies a medicalized disease orientation that lacks the developmental perspective critical to children’s services.
- 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.
- 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.
- 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.”
- 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.
- 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.  

- The term *recovery* may set unrealistic and universal expectations of “full cure” for children with severe behavioral health problems.  
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.  
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.

- 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.

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 & 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.\(^\text{156}\)

4. Reduce family, neighborhood, and community stressors.

5. Promote “positive chain reactions”—saturated support, guidance, and multiple opportunities during periods of elevated risk.\(^\text{157}\)

6. Provide access to family counseling and counseling for the children and adolescents of adults undergoing addiction treatment. Sankaran\(^\text{158}\) 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.

7. Provide youth-to-youth and parent-to-parent peer-based recovery support services.\(^\text{159}\)


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.\textsuperscript{160}

9. Provide assertive approaches to continuing support following specialized addiction treatment.\textsuperscript{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.

\textit{The Concepts and Language of Systems Transformation}

1. \textbf{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.”\textsuperscript{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.

**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
• 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.  

*Practice Guidelines*

1. **Develop distinct recovery/resiliency-oriented practice guidelines** for children/adolescents within all practice guideline documents.

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2. Explore development of a wide range of youth-to-youth and parent-to-
parent peer recovery support services, including family-to-family
outreach.\textsuperscript{164}

\textit{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.\textsuperscript{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.

\textit{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.

\textit{Develop a Youth/Family-Focused Peer Recovery Culture}

\textsuperscript{164} Smith, S.L., Hornberger, S., Brewington-Carr, S. Finck, C., O’Neill, C., Cavanaugh, D., & Bender, C.

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

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**

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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.

Acknowledgments: Work on this paper was supported by the Great Lakes Addiction Technology Transfer Center/Center for Substance Abuse Treatment/Substance Abuse and Mental Health Services Administration (#5 UD1 T1013593-07), the Philadelphia Department of Behavioral Health and Mental Retardation Services (DBH/MRS), and the Substance Abuse and Mental Health Services Administration’s Center for Substance Abuse Treatment (HHSS2832007006I/TO HHSS28300003T Subcontract No: s8440 ). The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of DBH/MRS, CSAT, SAMHSA, DHHS, or the Federal Government.

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

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hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members.”\textsuperscript{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.”\textsuperscript{175}

“Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship.”\textsuperscript{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).”\textsuperscript{177}

**Appendix B: Definitions of Resilience**

Resilience is the “ability of individuals to overcome adversity.”\textsuperscript{178}

“Resilience refers to a process of adaptation whereby individuals learn to overcome destabilizing effects resulting from traumatic experiences of greater or lesser severity.”\textsuperscript{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.”\textsuperscript{180}

\textsuperscript{174} Recovery Advisory Council, Philadelphia Department of Behavioral Health, 2005


\textsuperscript{179} Resilient children of parents affected by a dependency (2004) (Originally published as Comité Permanet de Lutte à la toxicomanie).

\textsuperscript{180} Resilient children of parents affected by a dependency (2004) (Originally published as Comité Permanet de Lutte à la toxicomanie)
“Resilience is the ability of individuals to remain healthy even in the presence of risk factors.”\textsuperscript{181}

“Resilience is a dynamic process encompassing positive adaptation within the context of significant adversity.”\textsuperscript{182}
