

Published in revised form in: Passetti, L.L. & White, W.L. (2009). Recovery support meetings for youths. *Student Assistance Journal*, 29(3), 19-22.

Recovery Support Meetings for Youths

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Abstract

Participation of young people in recovery support meetings is a promising yet largely understudied area. This article reviews the history of youth involvement in meetings, provides rationale for enhancing participation, summarizes current research, and discusses issues professionals may want to consider when making referrals. Based on information covered, professionals may want to research local meetings, help young people structure time before and after meetings, become familiar with group customs, investigate a variety of support groups, interact with support group service structures, develop a list of reliable group members to connect youths to the recovering community, and implement assertive referral strategies.

Keywords: Recovery support groups; 12-step; adolescent

Preparation of this manuscript was supported by funding from the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services through the Strengthening Communities-Youth project (grant no. T113356) and the National Institute on Drug Abuse, National Institutes of Health (grants no. 1 RO1 DA 018183 and 5 F31 DA17406 03). The content of this publication does not necessarily reflect the views or policies of the Department of Health and Human Services or the National Institutes of Health. The authors wish to acknowledge the support of CSAT project officers, Randy Muck and Jutta Butler. The authors also want to acknowledge feedback from Susan Godley and Mark Godley on drafts of this manuscript. For further information about this paper, please contact Lora Passetti at 309-827-6026, x.3316 or at lpasetti@chestnut.org.

Participation of young people in recovery support meetings is a promising yet largely understudied area in the field of substance abuse research. The

purposes of this article are to: 1) review the history of youth involvement in recovery support meetings; 2) provide a rationale for enhancing youth participation; 3) summarize current research on young people and recovery support groups; and 4) discuss issues professionals may want to consider when referring youths to 12-step and alternative groups, including strategies for linking young people to meetings. Much of this paper will focus on Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) because of their historical longevity, membership size, geographical dispersion and availability, and the number of scientific studies of their effects on long-term recovery outcomes.

History of Youth Involvement in Recovery Support Meetings

Professionally-directed and peer-based support structures for young people seeking recovery from severe alcohol and other drug problems have evolved over the past two centuries in tandem with youthful substance use trends (White, 1999). Nineteenth century recovery-support societies such as the Washingtonians and the Ribbon Reform Clubs sponsored “cadet” branches for young inebriates and launched “youth rescue” crusades (White, 1998). Many leaders of these efforts started their own downfalls as youth, one of whom even became known on the temperance lecture circuit as the “saved drunkard boy” (Foltz, 1891). Young people were admitted to nineteenth century inebriate homes, inebriate asylums and private addiction cure institutes, but there was no specialized adolescent treatment, nor youth-focused branches of such institutional aftercare groups as the Keeley Leagues (White, 1998). Alcohol problems among young people waned in tandem with the growth of the American temperance movement.

The heroin epidemic of the early twentieth century spurred rising juvenile arrests, the rejection of thousands of World War I draftees, and the admission of adolescents to morphine maintenance clinics that operated in 44 communities between 1919 and 1924 (Terry and Pellens, 1921). Of the more than 7,500 addicts registered at the Worth Street Clinic in New York City, 743 were under the age of 19 (Hubbard, 1920), but there is no record of any peer-based recovery support structures linked to these clinics. This lack of specialized recovery support resources continued as admissions of persons under age 21 to the two federal “narcotics farms” rose from 22 in 1947 to 440 in 1950. The dramatic rise of juvenile narcotic addiction in New York City in the early 1950s led to increased admissions to local hospitals (New York Academy of Medicine, 1953) and the 1952 opening of America’s first specialized addiction treatment facility for juveniles—Riverside Hospital. The eventual closure of Riverside in 1962 following studies confirming 95%+ post-treatment relapse rates led some to speculate that the Achilles heel in the Riverside Hospital design was its inability to

transfer institutional learning to the natural environment of those it treated (Gamso and Mason, 1958).

Peer-based recovery support structures for young people in the mid-twentieth century rose from three sources: AA, adaptations and alternatives to AA, and faith-based recovery ministries.

Young People's Groups in AA ("young people" then defined as AA members under age 35) began in the 1940s in cities such as Cleveland (1944), Los Angeles (1945), Philadelphia (1946), New York City (1947), and San Diego (1948). These increased through the 1940s to the point they commanded a special section of the 1950 International Convention of AA. In 1958, the growing network of Young People's Groups formed the International Conference of Young People in Alcoholics Anonymous and hosted their first convention in Niagara Falls, New York. That annual event now draws more than 3,000 young AA members from all over the United States (Special Composition Groups in A.A., 2002).

Young People's Groups were started in AA to escape the status very young members had as curiosities. The first *AA Grapevine* articles on young people in AA were published in the late 1940s under such titles as "Young Men Solve Meeting Problems" and "A Plea for the Young in Years," and the number of such articles grew significantly in the 1960s and 1970s. Over that span, ages of "young AA members" dropped from the 30s into the early twenties and then into the teens. A review of articles on young people in AA published in the *AA Grapevine* between 1948 and 1978 reveals that the young people who entered AA in these years faced incredulity and suspicion ("You're too young to be an alcoholic!"), condescension and disdain ("I've spilled more booze than you've drunk."), criticism ("We don't want to hear about those other drugs."), or were fawned over ("You are so lucky to have come to AA so young!"). A review of similar articles over the past 25 years reveals that such attitudes weakened as the average age of AA members progressively declined. In 1994, a regular feature of the *Grapevine* ("Youth Enjoying Sobriety") was begun that focused on young people in AA. Between 1948 and 2006, more than 100 articles have appeared in the *Grapevine* that focused on young people recovering within AA (B. Weiner, personal communication, November 30, 2006). Alateen, founded in 1957, also served as a source of support for adolescents who struggled with the alcoholism of a parent and a pathway of entry into recovery for some of these young people who went on to develop similar problems in their teen years.

Several things contributed to the rise of young people and very young adolescents entering AA. Lowered age of onset of regular alcohol and other drug use in the United States and the trend toward multiple drug use have accelerated the development of severe alcohol and other drug problems and triggered help-seeking at ever younger ages. Increased public awareness of alcohol and other

drug (AOD) problems and resources to resolve them along with reduced stigma may have increased the flow of young people into AA. The growing representation of youths may also signify a cumulative effect of young people in AA carrying a message of hope to others their age experiencing AOD problems and the growth of adolescent treatment programs that link their clients to AA for post-treatment recovery support. AA has also made an effort to reach out to young people through youth-oriented pamphlets (*Young People and AA, Too Young?*) and a film (*AA and Young People*). Young people's meetings can be located by contacting local AA Intergroups via the local AA telephone listing to request a meeting directory; statewide activities of young people in AA can be identified on the state conferences of young people in AA web sites (see www.e-aa.org/links/index.php?PID=9).

Other adaptations of AA's 12-step recovery program have attempted to reach out to young people. NA has attracted young people since its founding in the late 1940s and early 1950s. In 2005, there were over 21,500 registered NA groups holding over 33,500 meetings weekly. The birth of Pot smokers Anonymous (1968), Pills Anonymous (1975), Chemically Dependent Anonymous (1980), Cocaine Anonymous (1982), Heroin Anonymous, and Crystal Meth Anonymous reflect the continued evolution of AOD problems in America and the 12-step adaptations that have risen in response to them. There has also been a growth in secular alternatives to Twelve Step programs. The former include Women for Sobriety (1975), Secular Organization for Sobriety (1985), Rational Recovery (1986), Self Management and Recovery Training (SMART) (1994) and LifeRing Secular Recovery (1999). Explicitly religious approaches to addiction recovery include Alcoholics Victorious (1948), Alcoholics for Christ (1976), Overcomers Outreach (1977), Liontamers Anonymous (1980), and such recent groups as Ladies Victorious and Celebrate Recovery. Organizations such as Teen Challenge provide a religious alternative to secular treatment but have not generated autonomous, peer-based recovery support groups analogous to those linked to AA and NA.

This diversification of recovery support groups has not resulted in sufficient growth to create the equivalent of AA's Young People's groups, although such youth-oriented tracks could appear in the future. Queries to groups listed in the recovery mutual aid guide posted at the Faces and Voice of Recovery website (www.facesandvoicesofrecovery.org/resources/support_home.php) revealed only "a few" young people's NA meetings and one designated young people's meeting (Holland, Michigan) in Alcoholics Victorious. The first recovery support group organized specifically for adolescents in recovery is Teen-Anon (1999). Teen-Anon, affiliated with the California-based Streetcats Foundation for Youth and the

National Children's Coalition, has variations of its program for Christian teens, Jewish teens, and lesbian, gay and bisexual youth.

Rationale for Enhancing Youth Involvement

Following addiction treatment, most adolescents struggle with recovery and relapse. High relapse rates have been reported during the first 90 days after discharge from treatment (Brown, Vik, & Creamer, 1989; Dennis et al., 2004; Godley, Godley, & Dennis, 2001; Kennedy & Minami, 1993). Participation in professionally-directed continuing care groups can enhance substance use outcomes, but a substantial proportion of youths do not attend them unless assertive approaches that transfer responsibility of linkage and retention from the client to the clinician are employed (Godley, Godley, & Dennis, 2001; Godley, Godley, Dennis, Funk, & Passetti, 2002; Godley, Godley, Dennis, Funk, & Passetti, 2006).

Community-based groups are another potential source of recovery support for youths that can complement acute care interventions (Humphreys et al., 2004). As a free resource available in many communities, such groups can provide reminders of the negative consequences of substance use and the benefits of abstinence. Members offer experientially-based advice, are available 24 hours a day, and provide encouragement and opportunities for substance-free social events and interactions (Kaskutas, Bond, & Humphreys, 2002; Kelly, Myers, & Rodolico, in press). Such potential benefits merit further attention for youths.

Current Research on Youth Involvement in Recovery Support Meetings

The vast majority of research related to recovery support meetings has been conducted with adults attending 12-step-oriented groups, and a substantial body of published work supports the clinical practice of referring adults to 12-step meetings, recommending regular attendance, and encouraging involvement (Bond, Kaskutas, & Weisner, 2003; Connors, Tonigan, & Miller, 2001; Humphreys et al., 2004; Kissin, McLeod, & McKay, 2003; McKellar, Stewart, & Humphreys, 2003; Moos & Moos, 2004). On the other hand, research aimed at examining the effects of support group involvement on treatment and recovery outcomes for youths is still in its beginning stages. Studies have focused on youth participation in 12-step meetings, and no published studies of involvement in alternative groups were identified for this review.

The handful of existing studies designed to explore the helpfulness of young people's involvement in 12-step groups shows promise in this approach. To date, they indicate that adolescents who attend AA and/or NA after residential substance abuse treatment are more likely to remain abstinent, engage in less frequent substance use, and have better post-treatment outcomes than those who do not

(Alford, Koehler, & Leonard, 1991; Brown, Mott, & Myers, 1990; Hsieh, Hoffman, & Hollister, 1998; Kelly & Myers, 1997; Kelly, Myers, & Brown, 2000; Kelly, Myers, & Brown, 2002; Kennedy & Minami, 1993). Two of these studies identified self-help meeting attendance as one of the most powerful discriminators of abstinence from substances up to 6 and 12 months after discharge (Hsieh, Hoffman, & Hollister, 1998; Kennedy & Minami, 1993).

In their review of the literature on adolescent participation in AA and NA, Kelly & Myers (in press) suggest that while evidence is starting to accumulate that youths may benefit from participation in 12-step groups, conclusions on this subject are limited in four main ways: 1) only a small number of studies have been conducted; 2) all known published research has concentrated on adolescents discharged from residential or inpatient treatment, but no studies have yet examined 12-step involvement with adolescents treated in an outpatient setting; 3) research designs have been purely observational in nature, restricting the ability to make judgments about the effectiveness of youth participation in 12-step meetings; and 4) the 12-step construct has largely been measured in terms of attendance, pointing toward the need for additional information related to other dimensions of involvement, such as sponsor utilization, reading and comprehension of 12-step literature, and youths' understanding of the steps and how they are worked. Kelly & Myers (in press) advocate that future research studies include outpatient populations, focus on comparative efficacy and effectiveness studies of youth involvement in 12-step programs, better measure the 12-step construct, enhance understanding of developmentally-specific barriers to participation, include process studies to inform practice guidelines for professionals, collect more data regarding the frequency, spacing, intensity, and duration of 12-step participation by youths, and testing of 12-step facilitation efforts for adolescents.

Complicating efforts to maximize the benefits of youth attendance at recovery support meetings is the fact that, as with adults (Galaif & Sussman, 1995), a large number of adolescents who begin going to 12-step meetings eventually stop. One study revealed that the percentage of adolescents reporting attendance at one or more 12-step meetings dropped from 75% at 3-months post-residential discharge to 59% at 6-months (Kelly, Myers, & Brown, 2000). Another study discovered that 60% of adolescents in residential treatment attended 12-step meetings during the first 3 months after discharge, but only 38% did so at 12-months (Kennedy & Minami, 1993). In one sample, the odds that adolescents who discontinued 12-step meeting attendance used substances was almost three times that of those who kept going. Youths who dropped out were also about one-third more likely to report substance-related problems (Kelly & Moos, 2003).

Adolescents who are more likely to attend 12-step meetings and/or to become involved with them tend to present for treatment with more severe

substance abuse problems (Kelly, Myers, & Brown, 2002), have friends who use little to no substances, have been admitted to treatment more than once, experience more feelings of hopelessness, and receive less family participation in their treatment (Hohman & LeCroy, 1996). Further evidence suggests that professional 12-step inpatient programs facilitate AA and/or NA participation immediately following treatment for a number of clients, at least in the short-term (Kelly & Myers, in press; Passetti & Godley, 2007).

Results from another recent study that observed adolescents discharged from residential substance abuse treatment indicate that they, as a whole, perceived AA and/or NA to be important and helpful in their recovery, yet just over 1 in 4 perceived participation to be of little or no importance. On average, they felt connected to these recovery support groups, yet approximately 1 in 5 reported little or no feeling of connection to them. Aspects of AA and/or NA that youths reported liking the most were general group dynamic processes related to universality, support, and instillation of hope. The most common reasons adolescents reported for dropping out of 12-step groups included boredom, lack of fit with the group, and relapse. To a lesser extent, lack of perceived need to continue, low motivation, and the removal of external pressures to attend were also mentioned. The authors concluded that general group therapeutic factors, not 12-step specific ones, were most valued by adolescents during early stages of recovery and AA and/or NA exposure (Kelly, Myers, & Rodolico, in press).

Given the promise yet inconclusiveness of current research in the area of youth 12-step group involvement, providing clear recommendations for professionals working with youths experiencing substance abuse problems is challenging. Several issues, concerns, and barriers to the participation of young people have been raised in the literature or anecdotally by professionals and are raised below for further consideration.

Issues to Consider When Referring Youths to 12-Step and Alternative Support Groups

Potential iatrogenic effects of group interventions. One concern articulated in the literature on group interventions with youths is the potential of peers to contribute to the escalation of problem behaviors among young adolescents through “deviancy training.” Data from some research conducted with at-risk youths suggested that certain peer-group interventions unintentionally increased adolescent problem behavior and negative life outcomes in adulthood under some circumstances (Dishion, McCord, & Poulin, 1999; Dishion, Poulin, & Barraston, 2002), consequences which may be impacted by the characteristics of participants, the skill of group leaders, and the intervention context (Dishion & Dodge, 2005;

Gifford-Smith, Dodge, Dishion, & McCord, 2005). Importantly, these studies focused on preventive interventions for at-risk youth who were in pre- or early adolescence and had not yet developed a substance use disorder (Burleson, Kaminer, & Dennis, 2006).

Research with adolescents who have already developed substance use disorders has failed to identify peer contagion effects of group interventions. For example, Waldron and colleagues (2001) did not find negative outcomes for the group intervention included in their randomized trial of 4 substance abuse treatment models. Results from the Cannabis Youth Treatment (CYT) experiment (Dennis et al., 2004) indicated that all three group therapy conditions were associated with reduced substance use and problems during treatment and a follow-up period. Relative to individual and family interventions, there was no evidence of iatrogenic effects from group treatment in one of the largest randomized trials of adolescent substance abuse treatment. Additional examination of CYT data revealed that the composition of group members in terms of conduct disorder symptoms was not associated with worse substance use, psychological, environmental, or legal treatment outcomes. In fact, there was a slight advantage for youths with conduct disorder to be included in groups consisting of members with less severe symptoms. No results suggested that youths presenting with less severe conduct disorder failed to improve on outcome measures when exposed to youths with more severe symptoms, supporting the idea that group therapy for adolescents with substance use disorders is safe and effective (Burleson, Kaminer, & Dennis, 2006). Finally, a review of 66 studies by Weiss et al. (2005) did not discover any real evidence of systematic iatrogenic effects of group treatment of antisocial youths over the age of eleven.

These findings demonstrate that group interventions run by clinicians may not have negative effects on young people solely by virtue of the fact that they contain other youths with substance use disorders and behavioral problems. Recovery support meetings, however, are not traditionally run by professionals and are frequently comprised of mostly adults. Anecdotally, some clinicians have expressed apprehension about adolescents' attendance at 12-step meetings dedicated to youths. Issues of concern included the discovery of drug dealing at one youth meeting as well as the tendency for those groups to consist of a large gathering of newcomers (i.e., those without long-term sobriety), both circumstances that may test youths' ability to remain clean and sober. Young people who tend to make poor relationship choices could also form inappropriate relationships with other individuals, adult or adolescent, in meetings (Passetti & Godley, 2007).

Professionals who refer youths to recovery support groups may want to consider working with parents and caregivers to structure and supervise youths'

time before and after meetings to minimize the opportunity for negative interactions. Caregivers and professionals may also want to closely monitor attendance experiences and contacts made with other group members. No detailed research investigating potential harmful effects of same-aged or older recovery support group members on youths has been published, but some studies have investigated how the age composition of recovery support groups may impact youth attendance rates and outcomes.

Age composition of recovery support group meetings. While 12-step-oriented treatment approaches and referrals of youths to recovery support meetings are prevalent (Drug Strategies 2003; Jainchill, 2000), recent membership surveys of three common 12-step support groups reveal that less than 3% of their members are under the age of 21 (Alcoholics Anonymous, 2005; Cocaine Anonymous World Services, 2006; Narcotics Anonymous World Services, 2005). Rates of youth membership in 12-step alternative support groups are largely unknown, but a survey of LifeRing members indicated that less than 1% were under the age of 20 (LifeRing, 2005). Even though meetings dedicated to youths exist in some (but not all) communities, these statistics suggest that typical 12-step meetings consist largely of adults. Furthermore, Kelly and Myers (1997) found that 65% of the 12-step meetings attended by adolescents in that study were comprised mainly of older individuals. Such findings are meaningful because the substance use patterns and related problems of adults often differ from those of youths. For example, adolescents in treatment tend to use multiple substances concurrently and experience fewer medical complications, fewer withdrawal symptoms, and significantly shorter histories of substance abuse than adults (Brown, 1993; Stewart & Brown, 1995). They also tend to have less substance abuse problem recognition and motivation for abstinence (Tims et al., 2002). Adults may face difficulties related to loss of employment, loss of housing, and troubled relationships with spouses and children that youths cannot always identify with in their own lives.

Practice guidelines released by the American Psychiatric Association (1995) advise that young people generally function better in groups that consist of age-appropriate peers in addition to older members and that clients most likely benefit from groups containing individuals of similar age. Interviews with 30 clinicians employed in eight adolescent substance abuse treatment programs across the country revealed that age composition of group members was one of the most common factors considered when referring adolescents to 12-step meetings (Passetti & Godley, 2007). Research conducted to date supports the belief that those youths who attend meetings with at least a substantial proportion of adolescents after inpatient treatment have significantly better substance use outcomes (Kelly & Myers, 1997; Kelly, Myers, & Brown, 2005), higher frequency

of attendance, and greater perceptions of the importance of meeting attendance. Greater age similarity, however, was not found to be related to the increased likelihood of having a sponsor or engaging in social activities with other 12-step group members (Kelly, Myers, & Brown, 2005). Additionally, while interviews with clinicians indicated that they perceived adolescents to have difficulty relating to adults, a few mentioned that some youths seemed to prefer adult meetings for the wisdom and praise that could be received from older individuals (Passetti & Godley, 2007).

Based on this information, professionals referring youths to recovery support meetings may want to locate groups dedicated specifically to young people or that attract larger percentages of youths in an effort to maximize attendance, involvement, and substance use outcomes. Some clinicians have noticed that young people tend to like NA more than AA because it attracts a younger and more diverse crowd (Passetti & Godley, 2007). Professionals may benefit youths by speaking with them about their comfort level at meetings consisting mainly of adults and by recognizing that some youths could opt to attend a mixture of meetings, i.e., some with all youths, some with mostly youths, and some with mostly adults; however, meetings dedicated to young people are not available in all communities. Additionally, professionals may want to emphasize that other adolescents have benefited from support groups by feeling less lonely and more supported in their recovery efforts.

Ability of youths to understand and/or “buy into” program concepts.

Related to the issue that young people may not relate well to adults is the concern that youths may have difficulty understanding and embracing ideas framed in adult language in recovery support groups, especially ones grounded in the 12 steps. Concepts such as “acceptance,” “surrender,” and “spirituality” in 12-step programs are suspected to be too abstract for adolescents to grasp (Deas & Thomas, 2001; Passetti & Godley, 2007). Due to their relatively short substance use histories, youths may also find it problematic to admit powerlessness over alcohol or other drugs and commit to lifelong abstinence, especially if they do not meet criteria for substance dependence (Passetti and Godley, 2007).

Little systematic investigation has explored how young people perceive and interpret common concepts in recovery support groups. Preliminary results from qualitative interviews with adolescents in residential substance abuse treatment indicate that some young people acknowledge feelings of powerlessness over substances and recognize that their lives are unmanageable. For example, certain adolescents experienced loss of control over substance usage, school or work problems, strained relationships with other people, and substance-related legal involvement. The idea of “hitting bottom” was harder to identify with, and some

youths interviewed struggled with spirituality and comprehending 12-step literature. Steps related to making a fearless moral inventory and direct amends to people harmed were sometimes perceived as confusing or even frightening (Passetti, 2006). Interestingly, adolescents participating in the research presented by Kelly, Myers, & Rodolico (in press) did not report that the spiritual content of 12-step meetings was one of the main reasons for stopping attendance. On the other hand, 12-step-specific content was not a major reason for attending meetings early in the recovery process either. Both of these studies focused on youths admitted to residential treatment who tend to have more severe substance use histories than those admitted to less intensive treatment modalities; therefore, no conclusions can be drawn about the perceptions of young people with less severe substance use problems.

Since certain recovery support program concepts may be difficult to understand for some adolescents, professionals may want to review the language, concepts, and practices in those programs in order to prepare youths for what to expect during meetings (Forman, 2002) as well as to correct any misconceptions. Youths can be encouraged to discuss any concerns, confusion, or anxiety with other group members or sponsors.

Severity of youths' substance use and related problems. In one study, clinicians working in adolescent substance abuse treatment programs were more likely to refer youths to 12-step meetings if they presented with a high severity of substance use or were diagnosed with substance dependence rather than abuse. If adolescents demonstrated problems with substance use over a period of time or experienced serious or numerous consequences from their use, they were referred more frequently. A history of prior substance abuse treatment admissions and a greater openness to admitting that substance use was problematic also helped some clinicians determine that referrals were appropriate (Passetti & Godley, 2007).

While a previously discussed study indicated that adolescents with more severe substance use problems were more likely to attend 12-step meetings (Kelly, Myers, & Brown, 2002), no research has confirmed or refuted the idea that youths with less severe substance use problems do not benefit from recovery support groups, and debate on this issue exists. Passetti & Godley (2007) reported differing views articulated by various clinicians. Some felt that many adolescents will not go on to have lifelong issues with substances and that stories heard during 12-step meetings would be sensationalized. Others believed that exposing youths to 12-step groups could help them to explore the ideas of powerlessness and acceptance and to feel more comfortable accessing recovery support groups in the future if needed. Furthermore, adolescents may hear other people's stories and realize that their substance use was more serious than they originally thought. Even though future research is needed in this area, the cultures of recovery support

fellowships, networks, and associations may provide additional guidance for professionals referring youths with varying levels of substance abuse severity to meetings.

Cultures of recovery support fellowships, networks, and associations. When making referrals to recovery support groups, professionals would benefit from becoming familiar with the models from which they operate (Laudet, 2003), the activities in which members engage (Chappel & DuPont, 1999), and the subcultures that might exist (Holleran & MacMaster, 2005). In the case of AA or NA, knowledge of the 12 steps and 12-step concepts would enable professionals to speak knowledgeably to youths and to make the most informed referrals. Acquiring and reading group literature, visiting groups' internet sites, attending open meetings, and speaking with group members facilitate the process of learning group rules, concepts, language, and activities and the identification of group principles and guidelines, including membership requirements (White & Kurtz, 2006). For example, the only requirement for membership in AA is a desire to stop drinking (Alcoholics Anonymous World Services, 1972). If youths are not sure that they have a drinking problem or are reluctant to commit to abstinence, referrals to open meetings rather than closed ones may be more appropriate.

Familiarity with the variety of recovery support groups offered is important as well (Chappel & DuPont, 1999; Laudet & White, 2005; White & Kurtz, 2006). Not every youth will like 12-step meetings, and as established earlier, many stop attending over time. Some youths may find attending more than one type of group meeting helpful. By knowing about existing alternatives, professionals can provide youths with a menu of options for ongoing recovery support. Links to several mutual support groups can be found at the Faces and Voices of Recovery website mentioned earlier.

Cultures of local recovery support group meetings. In addition to knowledge about different support groups, information about specific meetings of those groups can help guide referral practices. Significant variation exists among individual support group meetings within the same fellowship, network, or association, both across and inside geographic regions (Montgomery, Miller, & Tonigan, 1993). Differences in cohesiveness, independence, aggressiveness, and expressiveness have been found between AA meetings as well as differences in the perceived amount of focus on working the steps and the 12-step program (Tonigan, Ashcroft, & Miller, 1995). One meeting is not necessarily like another.

Since recovery support group meetings can differ greatly from one another, professionals may benefit youths by gathering information about particular meetings in youths' communities and then using this data to match an individual young person with particular meetings based on needs, preferences, and cultural background (Humphreys et al., 2004; Laudet, 2003; Passetti & Godley, 2007).

Important considerations may include which ones have young participants, consist of members with long-term abstinence, have adult members that welcome young people, or have members that other youths have identified with previously (Passetti & Godley, 2007). For certain youths, the number of people that normally attend, a smoking or non-smoking designation, and/or substance of choice of group members may help determine which meeting to recommend. Other youths may be interested in meetings dedicated to certain groups of people based on gender or sexual orientation, speaker or discussion meetings, and/or meetings devoted to discussions of particular steps or traditions in 12-step oriented groups (Forman, 2002; Passetti & Godley, 2007). In the case of AA, it may be relevant to know which meetings are more or less tolerant of individuals who are dependent on substances other than alcohol (Passetti & Godley, 2007). Youths may need to be encouraged to try a variety of meetings before finding ones that they feel the most comfortable attending (Caldwell, 1998; Passetti & Godley, 2007).

Professionals can learn about the cultures of local recovery support group meetings in several ways. Colleagues and staff members of local substance abuse treatment agencies, particularly those who have identified themselves as recovering, may be valuable sources of information about local recovery support groups (Chappel & DuPont, 1999; Passetti & Godley, 2007). Youths with prior meeting experience can provide insights from their perspectives (Passetti & Godley, 2007). Additionally, professionals not in recovery may want to attend open meetings in targeted communities to become familiar with the dynamics of those specific groups.

The ability to recommend certain meetings for youths depends on the availability and accessibility of meetings in a given area. Urban and suburban regions will more likely have a range of options than small towns and rural locations. If a youth lives in a small town with only one adult AA meeting and has no transportation, choices are limited without creative intervention. School and employment schedules and curfews may also impact which meetings youths are able to attend. A lack of available recovery support meetings for adolescents in some geographical areas is triggering interest in telephone-based and internet-based recovery support services (Skinner et al., 2001; Kaminer & Napolitano, 2004). A helpful guide to such online recovery support groups can be found at the Faces and Voices of Recovery website.

Working with recovery support groups to connect youths to the recovering community. Most recovery support groups have service structures and procedures governing relationships with treatment organizations and other institutions. In AA, Hospitals and Institutions Committees or Treatment Facilities Committees work with organizations to bring meetings into facilities, encourage participation, coordinate temporary contact programs, and help arrange the purchase and

distribution of literature (Alcoholics Anonymous, 2007). Other 12-step groups typically have similar structures in place (White & Kurtz, 2006). When working with youths, professionals may decide to contact such committees to facilitate involvement in the recovering community. Committee members may also be willing to help start meetings dedicated to youths if they do not exist in a certain area.

Assertive linkage versus passive referral. In adult populations, assertively linking individuals to recovery support groups has proven to be a more successful strategy than passively recommending them to attend (White & Kurtz, 2006). Assertive linkage procedures may involve early referral to support groups, education about the potential benefits and risks of meeting attendance, ongoing monitoring of involvement and obstacles, and discussion of each person's prior experiences with, responses to, and perceptions of participation (Laudet, 2003; Ogborne, 1989; White & Kurtz, 2006). One study demonstrated that directly connecting someone to a 12-step group representative, rather than only providing meeting information and verbal encouragement, increased 12-step group attendance (Sisson & Mallams, 1981). While another study did not find greater attendance rates, referral procedures that proactively introduced adults to 12-step group volunteers, addressed concerns, set attendance goals, and encouraged finding a sponsor and a home group fostered greater participation in 12-step activities. Those adults that received this intervention demonstrated significantly higher abstinence rates from substances other than alcohol than those who did not, and those with less previous meeting attendance were more likely to attend a greater number of meetings (Timko, DeBenedetti, & Billow, 2006).

There have been additional recommendations to incorporate motivational interviewing principles into efforts to link individuals with support groups. A focus on enhancing motivation to change and abstain from substances, substance use problem acknowledgement, and recognition of the need for external support may promote attendance (Cloud et al., 2006; Laudet, 2003; White & Kurtz, 2006). In one study with adults admitted to an alcohol detoxification program, a 12-step motivational enhancement condition did not increase attendance at 12-step groups or improve drinking outcomes; however, the motivational approach was found to be more effective with individuals with little prior 12-step group experience (Kahler et al., 2004).

None of the above linkage strategies have been empirically tested with youths. Research in this area is needed to identify the most effective and appropriate referral strategies for young people. Motivational enhancement techniques may be especially appropriate for this population because of their tendency to have low substance use problem recognition and to have less experience with recovery support groups (Kelly, Myers, Rodolico, in press). One

study has provided preliminary information about the relationship between referral strategies of adolescent substance abuse treatment providers' and rates of self-help meeting attendance. Analyses of interviews with clinicians from eight sites across the United States revealed that staff located at sites with the highest overall rates of adolescent self-help meeting attendance tended to engage in certain activities that the other sites did not or did to a lesser extent. They actively linked youths to the recovery community in the following ways: 1) by bringing them to sober social activities sponsored by support groups (e.g., young peoples' conferences and sober dances, picnics, and retreats); 2) by working with service structures of support groups to host meetings and to locate good role models for youths; 3) by forming formal and informal networks of trusted people to accompany youths to meetings and/or to introduce them to the group; 4) by monitoring recovery support group attendance post-discharge through continuing care or case management; and 5) by helping youths identify and approach potential sponsors and then by interacting with and screening them for appropriateness. Appropriate sponsors possessed a good understanding of the 12-steps, worked the steps themselves, and had their own sponsor (Passetti & Godley, 2007).

Given these findings, professionals attempting to enhance youth attendance at recovery support groups may want to research support group-sponsored activities in youths' communities and assemble a list of *reliable*, diverse individuals that can serve as temporary guides to a particular support group (Forman, 2002; Johnson & Chappel, 1994; White & Kurtz, 2006). Group members that have experience with or are willing to work with young people and are knowledgeable about local meetings may be identified through the committees of various support groups, consultation with colleagues, prior experience with youths who are connected into the recovering community, or communication with staff at substance abuse treatment facilities. Ongoing monitoring of youths' interactions with group members, especially sponsors, and of their experiences at meetings may assist professionals in assessing the relationships that are formed as well as reactions and obstacles to participation.

Conclusion

Further investigation is clearly needed into the effectiveness of youth involvement in recovery support groups and into the usefulness of various referral strategies. Referrals to such groups are a promising avenue for future investigation. In order to assist young people in this area, professionals may want to engage in the following activities: 1) research the characteristics of local meetings, including age composition of members, so that referrals can be tailored based on youths' needs, preferences, and cultural backgrounds; 2) help young

people structure their time before and after meetings and with group members to minimize situations that may lead to relapse; 3) become familiar with group customs and languages in order to prepare youths for meetings, make appropriate referrals, and clear any misunderstandings; 4) investigate the variety of recovery support groups offered in a given area to provide youths with a menu of options; 5) recognize that some youths may need to try a diversity of meetings before finding one (or a combination of more than one) that feels comfortable; 6) interact with recovery support group service structures and develop a list of reliable group members to connect youths to the recovering community; and 7) implement assertive rather than passive referral strategies, including monitoring of reactions to experiences and program concepts.

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