

ADVOCATING FOR ADOLESCENT SUBSTANCE USE RECOVERY: AN ALTERNATIVE MODEL

Christina L. Chasek¹

University of Nebraska at Kearney, USA

Judith A. Nelson

University of Arizona, USA

Rochelle Cade

University of Mary Hardin-Baylor, USA

Kristin Page

University of the Cumberland, USA

Bryan Stare

University of North Carolina at Charlotte, USA

George Stoupas

Palm Beach State College, USA

Abstract. Adolescents at risk for substance use disorders face unique challenges in recovery when compared with adults. Counselors may seek to address developmental considerations with such clients, but often lack diagnostic and community resources necessary to provide holistic care. The Alternative Peer Group model shows promise in addressing adolescent recovery, however, more research is needed. We conclude from the limited research that has been conducted on APGs that there are positive aspects to consider in implementing this model including a positive peer group that offers support in recovery, 12-step meetings that are adapted specifically for adolescents, parent education and support, and community outreach to other treatment facilities and mental health providers. We also suggest that an important way to advocate for adolescent recovery from substance use disorder is for researchers to continue to conduct rigorous studies on this model as well as other promising recovery support systems for adolescents while recognizing the unique differences between adult and adolescent recovery.

Keywords: adolescent recovery, peer support groups, advocacy.

¹ Address for correspondence: Christina L. Chasek, Department of Counseling and School Psychology, University of Nebraska Kearney College of Education Building, Rm B-148, Kearney, NE 68849 Email: chasekc1@unk.edu

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According to the National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017), 1 in 10 individuals in the United States over the age of 12 have used illicit drugs in the past month and 1 in 4 young adults between the ages of 18 to 25 have used illicit drugs. During this same time period, 1.6 million adolescents ages 12–17 were current users of marijuana, 0.4 million adolescents were nonmedical users of prescription drugs, and 2.3 million adolescents were regular users of alcohol. Overall an estimated 1.1 million adolescents aged 12–17 had a diagnosable Substance Use Disorder in 2016. In 2016, an estimated 1.1 million adolescents aged 12–17 needed substance use treatment, however, only 0.7% of those actually received it (SAMHSA, 2017). These numbers reflect the on-going need for adolescent treatment and recovery services that target their unique developmental needs such as increased environmental pressure to use substances, heightened sensitivity to substances, lower tolerance, and developing cognitive processes that are incomplete and predispose the teen to taking risks.

Because of these unique needs, designing treatment and recovery programs for this population is often challenging. Providers must understand the unique signs of adolescent substance use, the risk factors associated with recovery for adolescents, the consequences of untreated substance use for adolescents, diagnostic issues related to adolescent substance use, and models that address adolescent recovery needs. This paper will explore the unique aspects of adolescent recovery, describe and propose an alternative model for recovery programs that are designed for this population, and suggest ways to advocate for strengthening adolescent recovery programs. Our aim is to provide information regarding adolescent substance use and recovery issues that will prompt mental health professionals who work with this population to consider the unique developmental needs of teens in recovery so that they might implement appropriate and effective interventions such as the model proposed in this paper.

SIGNS OF ADOLESCENT SUBSTANCE USE

The signs of adolescent substance use fall into two categories, physical and behavioral/cognitive (National Institute on Drug Abuse [NIDA], 2014). Adolescents who are misusing substances may show physical signs such as poor coordination, appetite changes, sleeping and waking problems, red watery eyes and pupil changes, runny nose or persistent cough, puffiness and swelling, nausea, abdominal pain, tremors, and irregular heartrate. Other physical signs include the smell of alcohol or smoke on the youth, needle marks on arms or legs, and difficulty speaking or breathing. There may be unexplained weight gain or loss, poor oral hygiene, sores, or constant scratching and picking (Ali et al., 2011). These symptoms are often mislabeled as other physical illnesses. However, if physical illness is ruled out then assessing for substance use should occur (NIDA, 2014).

The behavioral and cognitive signs of substance abuse are also often attributed to the normal attributes of puberty and turbulent developmental phases of adolescence (NIDA, 2014). Behavioral and cognitive signs should be carefully evaluated to determine if substances are an underlying case of such turbulence, as the earliest sign of adolescent substance use is a change in behavior and mannerisms (Ali et al., 2011, Castellanos-Ryan, Parent, Vitaro, & Tremblay, 2013). Adolescents who are abusing substances often have overall changes in personality, habits, and interests. Adolescents may withdraw from family members and become moody, oversensitive, irritable, or nervous (Copeland, Fisher, Moody, & Feinberg, 2018). Teens who are using substances often avoid usual family bonding time, routines, and activities (Ali et al., 2011). They may act aggressively or exhibit a lack of motivation and self-esteem. Youth may often change peer groups and activities, or exhibit a drop in academic or work performance and a lack of concentration or focus (Ali et al., 2011). Behaviors include dishonesty, secrecy, and stealing. Using room deodorizers and perfumes as well as possession of drug paraphernalia all point to substance use (NIDA, 2014). If these warning signs are taken seriously and are acted upon swiftly, there is great hope for recovery from substances.

RISK FACTORS AND CONSEQUENCES OF ADOLESCENT DRUG USE

According to Robertson, David, and Rao (2003), risk factors for adolescent drug use include family problems such as a lack of nurturing and ineffective parenting particularly during a child's early development. Drug use on the part of caregivers also puts children at risk (Will & Yaeger, 2003). Risk factors outside of the family system might include poor school behavior, academics, and associations with drug-abusing peers, particularly during adolescence. Community risk factors include the availability of drugs and trafficking patterns as well as a tolerance and acceptability of drug use (Monahan, Egan, Van Horn, Arthur, & Hawkins, 2011). Additionally, transitions that create a great deal of stress in children such as moving to a new neighborhood and school can cause them to turn to drug use. Children who have other mental health disorders, have low self-esteem, or who have been sexually abused might be at a higher risk for drug use.

The consequences of adolescent drug use are many, costly, and often have lasting effects for individuals, families, and communities. According to researchers (Centers for Disease Control, 2010; Sacks, Gonzales, Bouchery, Tomedi, & Brewer, 2015), excessive drinking was responsible for more than 4,300 deaths and \$24 billion in economic costs in 2010. These deaths included suicide, homicide, drunk driving accidents, and drug overdoses. According to the Youth Risk Behavior Survey (Centers for Disease Control, 2007), students who binge drank were more likely than those who did not binge drink to engage in risky and health compromising behaviors such as smoking, being sexually active, riding in a car with someone who is driving under the influence, being a victim of dating violence, attempting suicide, and using illicit drugs. Clearly the risks are great for adolescent drug and alcohol use making it important for the mental health community to understand the unique aspects of adolescent recovery so that these professionals are equipped to provide the best recovery support for this age group.

UNIQUE ASPECTS OF ADOLESCENT RECOVERY

Adolescent recovery has some unique aspects to it that differ from adults. First, states of recovery may look different in adolescent populations. According to the Betty Ford Institute, “Recovery may be the best word to summarize all the positive benefits to physical, mental and social health that can happen when alcohol – and other drug – dependent individuals get the help they need” (The Betty Ford Consensus Panel, 2007, p. 225). The word *recovery* is widely used as a term to describe complete abstinence from substance use. However, researchers point out that adolescents often return to drug use (or relapse) within one year of treatment, but many do not continue their substance-dependent behaviors into adulthood (Winters, Botzet, Fahnhorst, & Koskey, 2009). Satre, Mertens, Areal, and Weisner (2004) identified that adolescents experience more pressure to use chemical substances, thereby increasing their relapse potential. Therefore, recovery must be viewed within the context of day-to-day living. Researchers have also pointed out that recovery for an adolescent may be defined as a decrease in symptomology or harm reduction instead of total abstinence (Logan & Marlatt, 2010).

There are important considerations when looking at adolescents’ recovery processes and developing recovery programs. For example, adolescents might require a longer recovery period than adults due to developmental stage related challenges. They have not accomplished developmental tasks necessary for moving towards maturity, making recovery even more challenging than for a fully developed adult (Van der Westhuizen, 2015). Adolescents have a heightened sensitivity, compared with adults, to the effects of substances and addiction due to significant neurodevelopmental changes and environmental influences associated with their developmental stages (Brown et al., 2008; Mee-Lee, Shulman, Fishman, Gastfriend, & Griffith, 2001). While these enhanced effects can be detrimental, this is also the optimal time to provide interventions (Galvan, 2014; Steinberg, 2008). In addition, adolescents have unique developmental and psychiatric issues when compared with adults. Specifically, adolescents have a lower tolerance for substances due to their smaller body size and underdeveloped brain that increases their risk for drug use and physical consequences of that use (Galvan, 2014). Use of substances in adolescence can disrupt their overall development,

impairing their ability to handle life situations and to function independently (Van der Westhuizen, 2015). In addition, their awareness of feelings and the ability to deal with those feelings are not yet as well developed as adults (Van der Westhuizen, 2015).

Finally, adolescents have different environmental considerations than adults such as the strong influence of peer systems and less dependence on the family unit. Adolescents need to have a specific focus on building appropriate peer relationships, as they may not have developed these due to having missed typical developmental stages (Malhotra, Basu, & Gupta, 2007). Adolescents need to be reintegrated into their families, their communities, and their education systems (Van der Westhuizen, 2015). Yet, challenges still exist as mental health professionals attempt to appropriately diagnose adolescents and define what recovery for this unique group will look like.

CHALLENGES OF THE DSM-5 SYMPTOMOLOGY FOR ADOLESCENT ADDICTION

In 2013, the DSM-5 workgroup drastically changed the diagnostic criteria for what are now called substance use disorders (SUD). This involved the elimination of separate categories for abuse and dependence, replaced instead with a unitary diagnosis that included 11 possible symptoms ranging from social impairment to pharmacological criteria. While this change was met with both praise and criticism from experts in the field, it had particularly significant implications for adolescent treatment and prevention. As noted by Kaminer and Winters (2012), adolescents are not just miniature adults. Substance use and misuse at this stage of development is both quantitatively and qualitatively different from that of adults. According to the 2015 National Survey on Drug Use and Health (NSDUH), approximately 1.2 million adolescents aged 12 to 17 met the criteria for substance use disorder (Center for Behavioral Health Statistics and Quality, 2016). This amounts to about 5% of all adolescents, or 1 in 20. By contrast, the percentage of adults aged 18 to 26 who met the criteria for SUD was 15.3%; for those aged 26 and older, it was 6.9%. This disparity between adolescent and adult substance use softens slightly when considering not disorder criteria, but simply *any* illicit substance use. In the same survey year, 8.8% of adolescents reported

using illicit substances in the past month, whereas it was 22.3% of young adults (18-25) and 8.2% of those 26 years and older.

Winters (2013, 2011) identified a number of limitations to applying the DSM-5 criteria to adolescent substance use. Tolerance and withdrawal have long been seen as hallmarks of addiction; however, these psychopharmacological criteria demand special consideration when applied to adolescents. These symptoms correspond to neurological development and how long an individual has been using substances, both of which depend heavily on age. For example, a 12-year-old who has only recently started to use alcohol may respond very differently from a 17-year-old with the same behavior. Additionally, withdrawal typically appears only after years of heavy use; most adolescents simply have not been using long enough to experience this phenomenon. Another challenge was in how to conceptualize adolescent craving for substances. The DSM defines this as “an intense desire or urge for the drug”, often experienced in settings related to previous substance use (American Psychiatric Association, 2013, p. 483). Such an occurrence is a basic concept in classical conditioning: drug use produces pleasurable feelings, and so situations (i.e., people, places, and things) that remind the individual of these feelings will produce an urge to use the drugs again. When considering adolescents, however, the source of reinforcement may not be the substance itself. For example, teenagers whose drug use is rewarded by peer group approval may report cravings to use, when in fact it is the desire for socialization and peer group acceptance (Allen, Chango, Szewedo, Schad, & Marston, 2012; van Hemel-Ruiter, de Jong, Ostafin, & Oldehinkel, 2015). Another problem is the hazardous use criterion when assessing adolescents using DSM-5. For many counselors, the first scenario that comes to mind is driving under the influence of a substance. However, this situation does not apply to many adolescents because they do not have access to vehicles, hence this developmentally bound criterion requires special scrutiny with the adolescent population.

In creating the single SUD diagnosis, the DSM-5 authors developed criteria for differentiating mild, moderate, and severe presentations based on the number of symptoms present in the individual. For mild cases, the threshold was set at two symptoms. This means that a person could be formally diagnosed with a SUD if she had, for instance, craving and problems in school related to her substance use. As with the other

diagnostic guidelines previously mentioned, these criteria present challenges when applied to adolescents. Many of the symptoms outlined in the DSM-5 can be understood as normal experiences in adolescent development, such as risky behavior and experimentation. Using this framework to assess an adolescent's behavior may result in misdiagnosis in the affirmative, leaving him or her with the stigma associated with this lifelong label. To measure the impact of these changes on how counselors approach diagnosis, Kelly, Gryczynski, Mitchell, Kirk, O'Grady, and Schwartz (2014) examined the concordance between DSM-5 and DSM-IV nicotine, alcohol, and cannabis use disorder diagnoses among 525 adolescents. They found that diagnoses were more frequently given for all substances using the new criteria. Moreover, some adolescents who were previously considered *diagnostic orphans* because they did not meet criteria under DSM-IV, now qualified for a SUD. The authors conclude that the new criteria effectively widened the net, catching adolescents who would previously go undiagnosed. Haney-Caron, Brogan, NeMoyer, Kelley, and Heilbrun (2016) reached similar conclusions in their review of the impact of DSM-5 changes on juvenile justice. Taking adolescent differences from adults in recovery and the conundrum of the DSM-5 diagnostic criteria for SUD as it pertains to adolescents into consideration, recovery support interventions for adolescents is explored next.

RECOVERY SUPPORT SYSTEMS

According to the Substance Abuse and Mental Health Services Administration (2015), many behavioral health systems have made a dramatic shift in focusing on recovery as a state that anyone with substance use problems or mental health issues can attain. Recovery support systems move from an acute care or crisis centered approach to one that is a model of chronic care (Kaplan, 2008; White, 2002). Recovery and recovery oriented-behavioral health systems provide a positive and life-affirming approach to those who seek help, including adolescents. The following principles represent SAMHSA's (2012) working definition of recovery: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (p. 3). This definition provides a more thorough and inclusive

definition of recovery, rather than stating what recovery is not, namely the absence of the use of substances. Recovery is a state of being encompassing all aspects of an individual's life, and each person is empowered to choose the path to recovery that best fits his or her personal characteristics and situation. How one further develops and integrates these aspects of his or her life into a new state of being defines recovery. This meaning of recovery allows for unique opportunities of growth in working with adolescents, whose development in these areas is often less crystalized than those of adults. Mental health professionals are in unique positions to support adolescents in recovery from alcohol and drug use. One of those ways is to promote recovery support systems that provide teens with the unique tools that they need to recover from risky behaviors that can lead to morbidity and early mortality. We propose the use of an alternative model that is based solely on the needs of adolescents rather than using interventions such as Alcoholics Anonymous that have been successful with adult populations. While the model has been used since 1971, it has had renewed interest in the current decade due to increases in adolescent drug use and the need for interventions that are appropriate for the developmental stage of adolescence (Collier, Hilliker, & Onwuegbuzie, 2014). This model also aligns with the definition of recovery as it allows for adolescents to grow and recover in a community that addresses their health and wellness needs beyond remaining abstinent from substances.

A PROPOSED ALTERNATIVE MODEL: THE ALTERNATIVE PEER GROUP

The History of the Alternative Peer Group. The Alternative Peer Group (APG) model first appeared in 1971 in the Palmer Episcopal Church in downtown Houston, Texas, and was known as the Palmer Drug Abuse Program (PDAP). Formed by Father Charlie Wyatt-Brown, the Rector of Palmer Memorial Episcopal Church, the organization reached out to youth who wanted to recover from drug and alcohol use and provided them with love, support, and hope (Palmer Drug Abuse Program, n.d.). This intervention is based on the premise that Alcoholics Anonymous is not quite what teens in recovery need, but rather they require support from others their own age who are also in recovery, thus, an alternative

to those services that are designed for adult populations. Services at PDAP include weekly meetings; week-end sober activities; after school hangouts; individual, group, and family counseling; crisis intervention; presentations in schools and community centers; as well as considerable outreach through community organizations including school districts and juvenile justice probation services. All services are free of charge for the adolescent. The meetings follow a twelve-step program similar to that of Alcoholics Anonymous, but are designed to be peer driven by adolescents. Currently, PDAP in Houston, Texas has six satellite locations where meetings are held. In 2015, over 18,820 teens and young adults were positively impacted by the variety of services offered by PDAP (Nelson, 2016). Additionally, there are three other APGs located in Houston, listed on the website of the Association of Alternative Peer Groups and modeled after the PDAP intervention: Lifeway International, Teen and Family Services, and Beyond Your Best Counseling. There are PDAP locations in cities outside of Houston as well as additional agencies and treatment facilities that use the APG model, indicating a growing need for an alternative model of treatment for adolescents.

Current Research on the Alternative Peer Group. Although the APG intervention is used in treatment facilities for adolescents in community non-profit agencies, in sober high schools, and in some public schools, there is a paucity of research on this promising model. After a thorough search for information on APGs in articles, books, other manuscripts, and websites using the key words adolescent recovery, Alternative Peer Group, and alternative peer recovery models; the following studies and information were identified: a research study regarding the child-parent relationships of students who participated in an APG (Rochat, et al., 2011), one ethnographic study that resulted in a dissertation (Nash, 2013) and several articles (Nash, Marcus, Engebretson, & Bukstein, 2015; Nash & Collier, 2016), one conceptual article (Collier, Hilliker, & Onwuegbuzie, 2014), and a qualitative study (Nelson, Henderson, & Lackey, 2015). In addition, a number of websites, brochures, and other media that promote the APG intervention and some of the agencies and treatment facilities that make use of that model were found. Some of these include a video (Binarium Productions, 2011); a film, titled Generation Found (generationfoundfilm.com); the website of the Palmer Drug Abuse Program (n.d.); and the website of the Association of Alternative

Peer Groups (n.d). Keeping in mind the potential of this intervention and the limited research to date, a brief summary of the research that has been published to date and an ongoing study that is being conducted currently is described next.

Parent relations and the alternative peer group. Collier, Hilliker, and Onwuegbuzie (2014) noted the paucity of research regarding APGs and stated at the time of the publication of their article that only one research study on APGs had been conducted, at the Baylor College of Medicine (Rochat et al., 2011). This study compared 114 adolescents who participated in an APG with 127 students in a control group who were from a local high school. Results indicated that the APG participants experienced greater attachment, improved communication, and more trust with parents than the control group.

An ethnographic study of the alternative peer group. Based on Nash's (2013) dissertation, Nash, Marcus, Engebretson, & Bukstein (2015) published an ethnographic study of recent clients of the APG at Teen and Family Services (TFS) in Houston, Texas. Former teen clients were required to be successful graduates of the TFS APG in order to participate in the study and to assist the research team in uncovering the characteristics of successful adolescent recovery. The lead author spent 20 months interviewing the clients in individual and group settings as well as interviewing parents of the teen participants and the staff of TFS. The emergent themes and subthemes of this study included: I. Journey – a. preparation, b. engagement, c. working a program, d. recovery maintenance; and II. Relationships. Because the theme of relationships was closely linked to the four phases of the journey, the authors discussed the impact of the relationships in each phase. In addition, the researchers uncovered the following elements of adolescent SUD recovery: “. . . sober peers, fun, and a sense of belonging; structure and accountability; recovery narratives of peers who are farther along in the process; family support; community service; and extensive immersion in recovery-oriented support systems” (p. 305).

A conceptual article on the alternative peer group. Collier, Hilliker, and Onwuegbuzie (2014) stated that the purpose of their article was “to describe the history and model of the adolescent peer group, its place in the recovery-oriented systems of care (Kaplan, 2008) as a chronic-care approach, and implications for future research in social

influence, recovery capital, and long-term treatment for recovering youth” (p. 40). According to the authors, the components that make up the APG intervention are: the youth who seek recovery, social functions that provide venues for youth to interact with each other without the pressure of drug and alcohol use, 12-step meetings revised for youth, individual and group counseling, family support and counseling, and educational programs. The authors provided extensive implications and rationale for conducting more research on the APG (Collier, Hilliker, and Onwuegbuzie, 2014).

A qualitative study on the alternative peer group. Based on the recommendations of Collier, Hilliker, and Onwuegbuzie (2014), another research team focused on the early years of the APG intervention (Nelson, Henderson, & Lackey, 2015). Using an online social media platform of former PDAP clients, the authors of this study were able to post an announcement of their desire to interview those who have maintained long-term sobriety. Qualitative inquiries are often a good starting place for researching a concept or organization that has never been studied before. For this reason, the study was deemed a revelatory research project because no research had formerly been conducted on the early clients of an APG. Nineteen potential participants replied to the request, and ultimately 11 former PDAP clients submitted their informed consents, surveys, and contact information. The three researchers constructed an interview protocol and conducted telephone interviews of each of the 11 participants. The emergent themes and subthemes were: I. Relationships – a. with self, b. with peers, c. with a higher being; II. Before and After – a. life lessons, b. accountability, c. giving back; III. Dealing with resentments. Overall, the research team determined that there were significant therapeutic outcomes of the group work among peers and that the APG is an intervention of attraction in which teens desired to be together and supported each other in recovery (Nelson, Henderson, & Lackey, 2015).

A mixed methods study of alternative peer group. In 2015, PDAP created a program partnership with the Spring Branch Independent School District (SBISD) and the PaRC (Memorial Hermann Prevention & Recovery Center) both in Houston, Texas. This program was initiated with three middle schools and two high schools that consisted of high-risk students dealing with behavioral and substance abuse issues. In 2016 an additional three campuses were added which included high school aged

students. The program was designed to allow students who were referred to the Discipline Alternative Education Program (DAEP) to meet once a week with PDAP counselors in a support group setting in lieu of attending the DAEP. After the initial trial period of the intervention, the program was determined to be successful enough by school and PDAP personnel to continue to offer the program (Nelson, 2016).

Currently students are referred to the program by their administrators or counselors and are required to attend weekly meetings and weekend activities for six weeks, but they are able to continue to attend classes at their home campuses. During this period, individual and family counseling services are available by PDAP counselors. Students complete a pre-assessment and post-assessment when they enter and exit the program. Two valid and reliable assessments are the protocol for data collection of current clients in the Spring Branch ISD project. The two assessments are the Youth Risk Behavior Survey (CDC, 2015) and the Youth Quality of Life Survey (Topolski, Edwards, & Patrik, 2002). The two surveys were combined and administered in an on-line survey format. Personnel from PDAP and SBISD conducted the survey. Data analysis comparing pre and post assessment results revealed that 60% of the youth had been abstinent for 3 months post intervention compared with 42% pre-intervention (Nelson, 2016). Researchers (Collier, Hilliker, & Onwuegbuzie, 2014; Nelson, Henderson, & Lackey, 2015) believe that the APG intervention holds great promise for adolescent recovery from SUDs, and studies such as the mixed methods inquiry described above can provide much needed information regarding the effectiveness of this model in the schools.

We conclude from the limited research that has been conducted on APGs that there are positive aspects to consider in implementing this model. First of all, in all of the aforementioned studies, APGs meet the developmental needs of adolescents including attachment to a positive peer group that offers support in recovery (Kelly, Dow, Yeterian, & Kahler, 2010; Kelly, Myers, & Brown, 2005). Additionally, 12-step meetings that are adapted specifically for adolescents are an integral part of the APG model (Kelly, Myers, & Brown, 2005). Likewise, parental education and support is available and community outreach (e. g., mental health providers, hospitals, and treatment facilities) is accessed when needed (Kaplan, 2008). We suggest that an important way to advocate for adolescent SUD recovery

is to conduct rigorous studies on this model as well as other promising recovery support systems for adolescents including qualitative, quantitative, and mixed methods research. In addition, counseling professionals need to advocate for the support that adolescents need to recover from SUD recognizing the unique differences from adult recovery.

ADVOCATING FOR ADOLESCENT RECOVERY

The importance of recovery support for teens is clear and counselors have an important role in advocacy for recovery at local, state and national levels. The first step in these efforts is for counselors, psychologists, and other behavioral health professionals to become knowledgeable and familiar with local resources. This knowledge can aid in making and connecting referrals for teens and their families. In addition, the knowledge can serve behavioral health professionals in identifying gaps in services or needed support in their communities. Counselors and psychologists can initiate such support themselves, or participate in networking and community events to help others initiate these efforts to address the gaps in services.

Counselors and psychologists can also provide education in their communities as means of advocacy. This may include informal discussions with small groups at a church or larger more formal training or presentations for a non-profit agency or hospital. These efforts could provide accurate and current information to dispel myths and challenge stereotypes regarding adolescents and recovery. Content could also include appropriate and practical screening or assessment measures tailored towards the audience and their work setting. For example, counselors and psychologists could present options of practical assessments for medical professionals to use with each patient in a community clinic. Counselors and psychologists that are also educators or supervisors can also discuss advocacy for adolescents in a variety of courses including lifespan, counseling children and adolescents, substance use and abuse, counseling families, and assessment. In addition, keeping resources for students and supervisees to use and borrow is another means of expanding education and knowledge.

Finally, counselors and psychologists use their voice in advocacy at state and national levels in support of funding for adolescent recovery initiatives and efforts. Initial efforts would include learning the important persons to contact such as authors of legislation or the appropriate local, state, or national representatives. After identifying whom to contact, counselors and psychologists can call, email, or write legislators to advocate for Recovery Oriented Systems of Care such as the model proposed here. Furthermore, counselors and psychologists can combine their voice and advocacy efforts with state, national, and international associations or organizations as well. These voices can advocate for funding of education, prevention and treatment, and research for adolescent recovery.

CONCLUSION

The ever-increasing trend of illicit drug use by adolescents continues to put them at risk of substance use disorders and lack of access to treatment. They are especially vulnerable to short and long-term effects of substance use disorders, and face unique challenges to successful recovery in comparison with adult populations. Adolescents require therapeutic interventions and ongoing recovery supports that address their developmental needs, which many current adult recovery interventions and supports often fall short of addressing. According to Collier, Hiliker, and Onwuegbuzie (2014), the APG offers the recovery supports that are specific to the needs of adolescents (see Figure 1).

<i>Alternative Peer Group</i>					
Youth in Recovery	Social Functions: Bowling Dances Sports Celebrations Camping Hangouts	12-step Meetings: Altered for Adolescents	Counseling	Family Support: Parent Meetings and Referrals to Outside Agencies	Psychosocial Education

Figure 1. Adapted from Collier, Hiliker, & Onwuegbuzie (2014)

It is imperative that counselors, psychologists, and community support members continue to develop and advocate for empirically supported adolescent recovery models. The APG is one such model that preliminary researchers indicated to be effective in facilitating adolescent recovery from substance use. More research in this area is needed, the lack of which evidences the vulnerability of adolescents in recovery. Counselors and psychologists must advocate for this population by seeking further education and competency in this area; engaging in community outreach and information dissemination; and pushing for local, state, and national funding for adolescent recovery education, prevention, treatment, and research.

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PAAUGLIŲ PRIKLAUSOMYBĘ SUKELIANČIŲ MEDŽIAGŲ VARTOJIMO REABILITACIJA: ALTERNATYVUSIS MODELIS

Christina L. Chasek

University of Nebraska at Kearney, USA

Judith A. Nelson

University of Arizona, USA

Rochelle Cade

University of Mary Hardin-Baylor, USA

Kristin Page

University of the Cumberland, USA

Bryan Stare

University of North Carolina at Charlotte, USA

George Stoupas

Palm Beach State College, USA

Santrauka. Paauglių, kuriems būdinga rizika įgyti priklausomybę nuo įvairių narkotinių medžiagų, sveikimas gerokai skiriasi nuo suaugusiųjų. Konsultantai, dirbdami su tokiais klientais, galėtų labiau atsižvelgti į paauglių raidos ypatumus, tačiau dažnai jiems stinga diagnostinių priemonių ir bendruomeninių išteklių suteikti visapusišką pagalbą. Yra duomenų, kad Alternatyviosios bendraamžių grupės (ABG) modelis gali būti naudingas paaugliams sveikstant, tačiau dar trūksta tyrimais patvirtintų įrodymų. Iš esamų tyrimų darome išvadą, kad ABG modelis turi tam tikrų privalumų: pozityvi bendraamžių parama rehabilitacijos metu, dvylikos žingsnių susitikimai yra specialiai pritaikyti paaugliams, tėvai mokomi, jiems teikiama pagalba, bendruomenėje pasiekiamos kitos gydymo paslaugos ir psichikos sveikatos specialistai. Mes manome, kad propaguojant paauglių sveikimą nuo priklausomybę sukeliančių medžiagų vartojimo sutrikimo svarbu, kad mokslininkai tęstų validžius tyrimus modelio efektyvumui patikrinti, taip pat ieškotų kitų efektyvių paramos sveikstant sistemų paaugliams, pripažįstant svarbius skirtumus tarp paauglių ir suaugusiųjų rehabilitacijos proceso.

Reikšminiai žodžiai: paauglių rehabilitacija, bendraamžių paramos grupės, propagavimas.

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