



# Substance Use Disorder Transition Age Youth

## Peer Delivered Services - Best Practices Curriculum

**The Regional Facilitation Center**

**DACUM Facilitator/Authors**  
**Eric Martin**, MAC, CADC III, PRC, CPS,  
**Tony Vezina**, A.A.S., PRC,  
**David Gardiepy**, B.A., CADC II

**DACUM Youth Peer SME Workgroup**  
Michelle Courtney, CRM  
Cody Roberts, CRM  
Gaile Parker, B.S., CRM

**DACUM Qualitative & Managerial Editors**  
William White, M.A.  
Sean Syrek, B.S., B.A., PRC, PSS  
Van Burnham IV, B. Accy, CRM  
Michael Razavi, MPH, CADCI, PRC, CPS

June 2017

# SUD Transition Age Youth Peer Delivered Services Best Practice Curriculum

---

The Regional Facilitation Center  
maapp.org

## DACUM Facilitators & Authors

**Eric Martin**, MAC, CADC III, PRC, CPS,

**Tony Vezina**, A.A.S., PRC,

**David Gardiepy**, B.A., CADC II

## DACUM SME Workgroup

**Michelle Courtney**, A.A., QMHA, CRM

**Cody Roberts**, CRM

**Gaile Parker**, B.S., CRM

## DACUM Qualitative & Managerial Editors

**William White**, M.A.

**Sean Syrek**, B.S., B.A., PRC, PSS

**Van Burnham IV**, B. Accy, CRM

**Michael Razavi**, MPH, CADC I, PRC, CPS

## ***Acknowledgements:***

*The Portland Regional Facilitation Center would like to acknowledge the support and contributions of the 4<sup>th</sup> Dimension Recovery Center for youth. Their lived-experience, youth peer delivered services experience and their capacity for youth survey work, made this curriculum possible! 4<sup>th</sup> Dimension Recovery Center serves 40 peer program youth participants monthly. Simultaneously, they serve over 600 unique youth monthly in their community recovery center, providing a safe venue for recovery oriented socialization, recovery meetings, and recovery events.*

*We would also like to acknowledge the participation of Mental Health Association of Oregon for their support and participation in the production of this curriculum.*



**4<sup>th</sup> Dimension Recovery Center**  
3807 NE Martin Luther King Jr Blvd,  
Portland, Oregon 97212  
**4Drecovery.org**



**MHAO**  
10373 NE Hancock St, Suite 132  
Portland, Oregon 97220  
**mhaoforegon.org**

## Introduction

While much has been researched and authored regarding adolescent addiction treatment, and general K-12 youth mentoring, very little has been written about SUD peer delivered services for transition age youth (White & Godley, 2007). SUD youth peer best practices and competencies are glaringly absent from the literature.

This best practice curriculum was developed with the support of the 4<sup>th</sup> Dimension Recovery Center, a transition age youth community recovery center in Portland, Oregon.

This DACUM best practice curriculum analysis is offered, using a series of investigative protocols, including: a review of the literature, DACUM (Developing A Curriculum) Subject Matter Expert workgroup, quantitative youth peer validation survey, and a managerial and administrative validation review. This best practice analysis is specifically designed for training purposes. Best practices with specific KSA's (Knowledge, Skills, and Attitudes) are described in checkboxes for classroom participant self-assessment.

## Classroom Directions

This text is designed for in-class training.

1. Review and discuss a Best Practice.
2. Ask each participant to complete the associated self-assessment. The self-assessment check box can also be used as an "agency self-assessment" check box.
3. In groups, have participants discuss their strengths and areas needing

improvement based on their self-assessment.

4. Facilitate a class discussion around the insights gained by individuals through self-assessment and group discussions.
5. Move on to the next Best Practice and repeat the process.

## Methodology

1. **Stage One: Review of the Literature.** We identified major documents specific to youth recovery most notably William White & Rita Chaney's Scientific and Professional Literature on Addiction Recovery/Peer Recovery Support Services (PRSS) for Adolescents and Transition Age Youth, a literature review of 227 journal articles and Historical Milestones in Recovery from Substance Use Disorders among American Adolescents and Transition-age Youth (with a Particular Focus on Peer Recovery Support), a historical literature review of 29 documents. Few of these documents were specific to TAY peer services, however many were related to adolescent and young adult recovery. We identified 15 common themes in those documents related to youth peer services.
2. **Stage Two: DACUM Subject Matter Experts (SME).** The SME were assembled from experienced youth peers, all of whom are in long-term recovery from a substance use disorder. The workgroup analyzed the literature review and generated best practices frequently identified in the literature. The SME edited language and developed organizational storyboard attributes to the best practice and KSA task descriptions.
3. **Stage Three: Quantitative Youth Peer Likert Validation Surveys.** The SME developed survey questions for youth peers regarding Best Practices. Youth peers completed the Likert survey and feedback portion of the validation survey, with subsequent edits to Best Practices based on results (mean, median, variance, confidence intervals, and standard deviation). (Appendix #1)
4. **Stage Four: Qualitative Managerial & Administrative Validation.** A draft document

was distributed to administrative subject matter experts with peer/recovery experience for validation through managerial and administrative review, with subsequent edits to Best Practices based on results.

5. **Stage Five: DACUM Curriculum.** Final edits to the Best Practices were produced by the SME and the curriculum self-assessment grids were completed for training and self-evaluation.

---

## Literature Review and SME DACUM Workgroup

### DACUM Lead Facilitator:

**Eric Martin, MAC, CADC III, PRC, CPS**

[Eric@ACCBO.com](mailto:Eric@ACCBO.com)

- Peer Trainer, Daystar Education
- Peer Consultant, 4<sup>th</sup> Dimension Recovery Center
- Supervisor, VPGR Peer Services
- Peer Delivered Services Researcher, Health Share of Oregon
- Director, MetroPlus Association of Addiction Peer Professionals

### DACUM Facilitator:

**Tony Vezina, A.A.S., PRC**

- Executive Director, 4<sup>th</sup> Dimension Recovery Center
- Youth Peer Mentor, 4<sup>th</sup> Dimension Recovery Center
- Traditional Health Worker Commissioner

### DACUM Facilitator:

**David Gardiepy, B.A., CADC II**

- Peer Mentor & Trainer

**Michelle Courtney, CRM**

- Peer Mentor, Multnomah County LEAD Law Enforcement Assisted Diversion
- Board of Directors and Volunteer Youth Mentor, 4<sup>th</sup> Dimension Recovery Center

**Cody Roberts, CRM**

- Youth Peer Mentor, 4<sup>th</sup> Dimension Recovery Center

**Gail Parker, B.S., CRM**

- Youth Peer Mentor, 4<sup>th</sup> Dimension Recovery Center

## Qualitative Review Editors

**William White, M.A.**

- Emeritus Senior Research Consultant, Chestnut Health Systems

**Sean Syrek, B.S., B.A., PRC, PSS**

- Supervisor, MHAO Forensic Peer Services

**Van Burnham IV, B.Accy., CRM**

- Board of Directors and Volunteer Youth Peer Mentor, 4<sup>th</sup> Dimension Recovery Center
- Co-Director, Addiction Counselor Certification Board of Oregon

---

This Best Practice Analysis was funded through The Regional Facilitation Center Grant from the Oregon Health Authority, Health Services Division.

### Recommended Citation:

Martin, E., Vezina, T., Gardiepy, D., Courtney, M., Roberts, C., and Parker, G. (2017). Substance Use Disorder Transition Age Youth Peer Delivered Services Best Practice Curriculum, The Regional Facilitation Center, Portland, Oregon, [maapp.org](http://maapp.org)

# SUD Transition Age Youth Peer Delivered Services Best Practice Curriculum

---

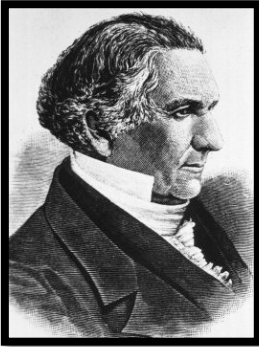
Forward: The History of Youth Recovery

Section One: Building TAY SUD Peer Delivered Services

Section Two: SUD Youth Recovery Community

Section Three: SUD Youth Peer Services

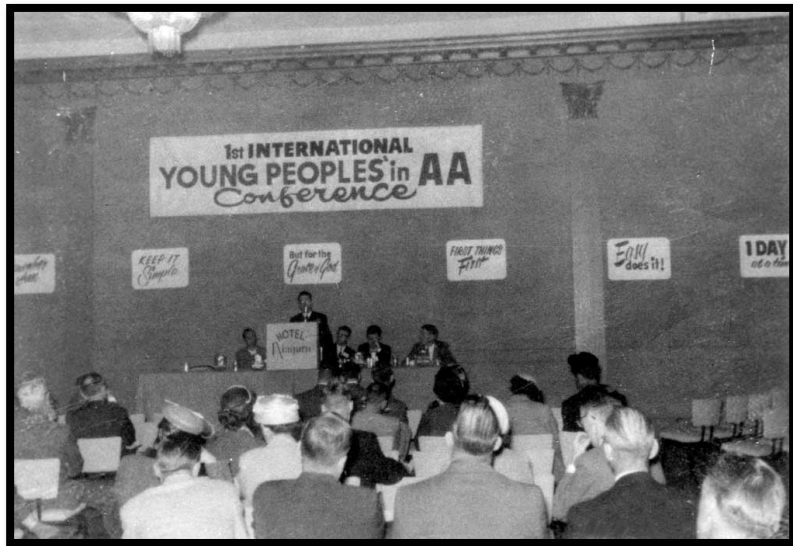
## Forward: A Brief History of Youth Addiction Peer Recovery



Concern regarding youth substance use dates back to the early 1800's. Dr. Samuel Woodward noted that early onset drinking was more likely to induce alcoholism later in years. He advocated for the development of youth services within inebriate asylums to intervene on these early onset consumers of alcohol. Similarly, today many youth peer programs work with individuals who began consuming alcohol and drugs from very early ages. By the mid-1800's, recovery support societies began sponsoring "cadet" groups for young inebriates launching "youth rescue" crusades. One such travelling crusade on the lecture circuit featured the "Saved Drunkard Boy" (Foltz, 1891). These efforts to recruit young people recovering from alcohol problems constitute America's earliest interventions, and possibly the first "youth peer support" to address alcoholism among young people.

In the 1940's, members of Alcoholics Anonymous witnessed an increase in youthful members attending meetings, and "35 and under" groups began in Philadelphia and New York. By the late 1940's and early 1950's, mutual aid fellowships for persons addicted to drugs began to form, including Habit Forming Drugs, Hypes and Alcoholics, Addicts Anonymous, and Narcotics Anonymous.

In 1958, the International Conference of Young People in A.A. (ICYPAA) was founded. At that time, Alcoholics Anonymous offered ongoing supports for these efforts, including the development of youth literature; Young People and A.A., Too Young?, and a film A.A. and Young People. The A.A. Grapevine also began routinely publishing articles regarding youth in recovery.



Many youth-oriented outreach programs, outpatient counseling services, and school-based early intervention programs were started in the late 1960's and early 1970's in response to problems resulting from rising polydrug use. By the late 1970's, collegiate recovery support programs were developed at a variety of colleges, including Brown, Rutgers, and Texas Tech. Recovery High Schools and Alternative Peer Groups (APG) began largely as alternative GED completion programs in Texas and Maryland and then evolved into more formalized recovery support programs. Minnesota's

Ecole Nouvelle (now Sobriety High) was established in 1986 and opened in a community center with four students and one teacher. Early school-based recovery programs operated with the administrative goal of academic retention and completion, using youth peer support to achieve that aim.

In the 1980's, changes in insurance reimbursement spurred the growth of hospital-based and freestanding addiction treatment programs. Adolescent inpatient admissions rose from 50,000 in 1984 to 250,000 by 1989. Most of these adolescent programs were differentiated from traditional adult treatment services by adapting elements of therapeutic communities and positive peer culture to enhance long-term recovery outcomes. Subsequently, with many adolescents leaving addiction treatment with little support, longer-term after-school outpatient and aftercare programs began, as well as Recovery Support Groups within local high schools throughout the U.S. funded by Safe and Drug Free Schools. Development of school-based recovery support programs was enhanced by the subsequent founding of the Association of Recovery Schools and the Association of Recovery in Higher Education.

In 2007, FreeMind began in Tucson, Arizona with the mission of creating safe meeting places and peer-led support for youth in recovery from addiction. A federal evaluation of this program revealed, in a 21-month period, 197 participants completed the intake process and the 6-month follow-up evaluation.

***The report showed that 82% of participating youth sustained or initiated recovery after starting FreeMind and illegal activity decreased 57%.***

In 2011, Young People in Recovery (YPR) was founded as a youth-focused advocacy organization. The organization currently produces youth peer delivered curriculums, including EPIC and Phoenix.

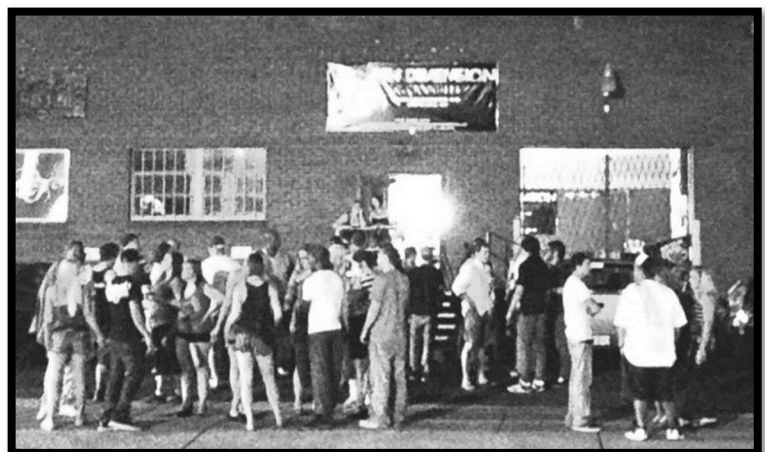
In 2013, Transforming Youth Recovery (TYR) was founded by the Stacie Mathewson Foundation.



Transforming Youth Recovery  
One Community, One School, One Student At A Time

TYR has produced toolkits and curriculum for collegiate youth recovery programs. The Stacie Mathewson Foundation also produced organizational standards and research surveys for collegiate youth recovery programs, including a review of youth peer assets and competencies.

During this same period, 4<sup>th</sup> Dimension Young People's Recovery Club was founded in an old warehouse in Portland, Oregon. The organization began as a 12-step recovery club for young people. In 2014, its mission was expanded and it subsequently evolved into the 4<sup>th</sup> Dimension Recovery Center, and





began offering youth peer services for individuals 13-35 in recovery from addiction. Over a one-year period, 4<sup>th</sup> Dimension Recovery Center served 114 individuals, ages 30 and younger in the peer support program, while simultaneously serving approximately 600 young people per month in their recovery center (12-step meetings, events, etc.). The 2016 annual impact report reveals, that of the 114 peer program participants:

- **65% remained abstinent**
- **41% gained needed housing assistance**
- **42% improved their employment (gaining employment or better employment)**
- **20% enrolled in an educational program**




It is noteworthy to mention that over the past decade, numerous youth mental health peer support organizations, including Youth M.O.V.E. National, have made great strides in reducing substance use and related problems among young people with mental health challenges.

For the purposes of this DACUM analysis and resulting best practice curriculum, our focus is on peer services for adolescents and young adults primarily struggling with addiction.


# Section One: Building TAY Peer Delivered Services

**Best Practice One: SUD Peer Services Created, Directed, and Delivered by Youth.** SUD youth peer services are best designed, operationalized and administered by youth. Youth-centric services include: policies regarding age of individuals served; youth-centric hours of operation for peer services, drop-in hours and events; youth-oriented outreach, geographical accessibility, including access to public transportation; youth-oriented policies & procedures; and greater opportunities for consumer involvement within the agency. A 2015 nationwide survey of 145 College Recovery Programs (CRP's) found that the highest ranking asset in starting a college recovery program was existing students in recovery who were motivated in developing one.







 <b>Self-Assessment Checklist ✓</b>	
<b>Best Practice #1: SUD Peer Services Created, Directed, and Delivered by Youth</b>	
<input type="checkbox"/>	Youth involvement in the design, delivery, and evaluation of peer-based recovery support services reflects authenticity of representation (youth in SUD recovery who do not represent other institutional interests) and diversity of representation (e.g., cultural diversity, spectrum of problem severity, and diverse pathways and styles of recovery). The peer delivered services program is administered by youth in recovery, including: the majority of the board of directors, managers, and all peer staff (CSAT, 2006, Quality Indicator 2).
<input type="checkbox"/>	The program has established policies & procedures regarding: age of individuals being served, youth-centric hours of operation, outreach, youth accessible facility location, youth-empowering grievance and feedback policies, promotion of consumer involvement, general peer services, employee practices, health and safety, etc. (CSAT, 2006, Quality Indicator 12).
<input type="checkbox"/>	The program affords opportunities for youth consumers to be involved, including leadership roles within the program. The program affords opportunities for youth consumers to have a greater voice in the design, aesthetics, branding, activities, direction, policies, programming, etc. of the organization, compared to limited opportunities afforded to consumers in the traditional behavioral health care system (CSAT, 2006, Quality Indicator 4).
<input type="checkbox"/>	The program has user-friendly documentation procedures for youth peers. Required documentation and data collection is meaningful and can be understood by youth peers.
<input type="checkbox"/>	Program may utilize autonomous outside technical assistance and mentoring from professionals who may be older than 35, who can assist with legal questions and business operations: 501(c)3 non-profit status, Secretary of State business registration, 990 filing, trademark registrations, general principles of accounting including segregation of duties, payroll, payroll deductions, development of bylaws, board responsibilities, liability insurance, responding to Request for Proposals [RFP's], grants, policies & procedures, employment law, etc. Good governance is vital for youth peer programs. Youth peer programs reach out to

	older adults for assistance in developing good youth governance (CSAT, 2006, Quality Indicator 12).
--	---


**✓ Best Practice Two: Branding.** Branding is an important element of youth peer delivered services. Branding requires input from peer staff and consumers, involving values important to young people in recovery: such as socialization, non-traditional care, equity, advocacy, empowerment, and non-traditional designs that incorporate social media. The Mathewson Foundation TYR Toolkits highlight the imperative of “branding” for collegiate youth peer programs.

 <b>Self-Assessment Checklist ✓</b>	
<b>Best Practice #2: Branding</b>	
<input type="checkbox"/>	Branding is created by and for youth. Where traditional behavioral health services might engage a marketing company to create their branding, logo and artwork, youth peer delivered services branding often involves both the staff/volunteers of youth peer programs and the youth being served.
<input type="checkbox"/>	Branding typically reflects values of non-traditional behavioral health care including advocacy terms like “movement,” “power,” “voices,” “consent,” and “alternatives.”
<input type="checkbox"/>	Branding often involves the use of social media and self-assessment tools that highlight the importance of individuals evaluating themselves vs. being judged, evaluated and diagnosed by others (Harris & Knight, 2014; Hu et al, 2014).
<input type="checkbox"/>	Youth branding focuses on socialization (see below) vs. the expected outcomes of “pleasant peaceful change” implicitly promised by traditional addiction treatment programs with serene logos and narratives like “serenity,” “first step,” “journey’s,” “awakenings,” “new beginnings,” “stepping stones,” or treatment centers that are located in serene locations “...by the sea,” “...by the woods,” “...by the briar,” “...by the lake,” etc. that are more appealing to older adults.

Examples of peer youth branding:

		
<p>Youth M.O.V.E.'s National logo for youth peer services.</p>	<p>Youth M.O.V.E. National messaging.</p>	<p>4<sup>th</sup> Dimension Recovery Center logo, Portland, Oregon.</p>
		
<p>4<sup>th</sup> Dimension Recovery Center announcement for a popular youth recovery event.</p>	<p>International Conference of Young People in Alcoholics Anonymous' announcement regarding conference events, including: Idol contest, rap battles, a drag show, and an open mic.</p>	<p>International Conference of Young People in Alcoholics Anonymous' announcement regarding elections and efforts to lobby for the national ICYPAA convention to occur in Chicago. The announcement encourages individuals to go to the CHICYPAA Facebook page for more information.</p>

✓ **Best Practice Three: Dedicated Safe Physical Space.** Youth require a dedicated space designed for safety versus “appropriateness” or administrative convenience. A dedicated functional space demonstrates a commitment to youth recovery. Historically, many collegiate recovery programs have been relegated to small rooms little more than closets, simply for administrative convenience. The collegiate recovery literature often describes feelings of undervaluation and stigma experienced by SUD youth staff, volunteers, and participants when they aren’t afforded adequate space.


 <b>Self-Assessment Checklist ✓</b>	
<b>Best Practice #3: Dedicated Physical Safe Space</b>	
<input type="checkbox"/>	Youth peer programs ensure adequate and functional space dedicated solely to youth peer services.
<input type="checkbox"/>	The space is designed for safety. Safety is the primary concern of youth peer programs vs. traditional values around appropriate dress and decorum. “Take off your hat, no swearing, no shirt, no shoes, no service” is replaced by “no drugs, no alcohol, no violence, no hate speech.” Appropriateness does not focus on an individual’s appearance, dress, or psychosocial unconventionality. Rather, the focus is on behavior or speech that promotes or incites racism, sexism, homophobia, transphobia, bullying, or other threatening behaviors.
<input type="checkbox"/>	Safety includes a physical design with private areas for peer 1:1 support. Spaces should have high visibility in all areas and no locking doors on private meeting rooms or restrooms. Having high visibility and no locking doors promotes an atmosphere free of sexual activity, aggression or assault.
<input type="checkbox"/>	Youth peers provide education and support for sexual health. Youth peers respect gender, sexual identity, and gender expression. Youth peers support a culture of sexual safety, health and wellness, including education and information regarding sexually transmitted disease.
<input type="checkbox"/>	Safety also includes policies, procedures and training regarding Mandatory Reporting of the abuse of minors, and legal compliance with local statutes. It is the role of youth peer staff to report “suspected abuse” vs. “substantiated abuse” that “rises to the level of reporting,” often referred to as “reasonable suspicion.” It is the responsibility of youth peer staff to report suspected abuse and it is the responsibility of child welfare staff to investigate and potentially substantiate abuse of minors. Mixing young adults and minors in the same space, support groups and events creates challenges for peer programs. Youth peer programs create awareness of Mandatory Reporting requirements and create a culture that is safe for minors and those over 18 years of age. While 12-step meetings have proven to be relatively safe, recovery centers are open in-between meetings and that space is monitored by youth peers to maintain safety and security (Sussman, 2010; Kelly, Dow, et al, 2011).
<input type="checkbox"/>	Depending on the nature of services offered, programs may wish to separate adult and adolescent “peer group services and activities” to minimize safety risk for adolescents who might encounter young adults within community recovery centers. Programs may also wish to screen peer program adult participants for histories of violence or sex offenses if there are any mixed services that combine adolescents with young adults in the same groups or activities.

<input type="checkbox"/>	Youth programs maintain policies regarding staff safety, including policies and procedures for a variety of critical incidents, including emergency contacts.
<input type="checkbox"/>	“Event/Activity-based recovery” is an important feature of youth peer services. The physical space and/or available space should be large enough to host a variety of youth recovery events, including, but not limited to: recovery meetings, speaker meetings, dances, rap battles, battle of the bands, art shows, speaking events, poetry nights, comedy shows, movie nights, physical activities, drag shows, BBQ’s and other food events, etc.

## Section Two: SUD Youth Recovery Community

### ✓ **Best Practice Four: Building Youth Social & Recovery**


**Communities.** SUD youth peer services have a greater focus on affiliation and socialization vs. individual and emotional support. Research regarding youth substance abuse and abstinence, reveals that both are correlated to broader peer groups and social influences. Youth peer services assist consumers with integration into the larger youth recovery community, creating a sense of “community” or “family.” Building a youth recovery community requires empowerment through shared responsibilities, leadership development, and respect for diverse pathways (White, 2009).

 <b>Self-Assessment Checklist ✓</b>	
<b>Best Practice #4: Building Youth Social &amp; Recovery Communities</b>	
<input type="checkbox"/>	Youth peer services are focused on affiliating youth with other youth in recovery. This involves facilitating transportation, encouragement, and reminders regarding youth meetings, support groups, get-togethers, parties and events. Research supports youth peer services to reduce youth substance use and related problems (Buckley et al, 2009; Collier et al., 2012). Engaging with other youth in recovery dramatically elevates recovery outcomes (Litt et al., 2007, 2009).
<input type="checkbox"/>	Youth peers are knowledgeable regarding youth attendance at community recovery support groups and assertively link young people to those groups that are most heavily attended by other youth. Many youths feel they do not “fit into” community support groups due to a preponderance of older adults (Kelly, Myers, & Rodolico, 2008). Research reveals that youth meeting attendance rises when there are more youth represented in the group (Kelly, J.F., Myers, & Brown, 2005).
<input type="checkbox"/>	Peers encourage youth to make new friends in recovery and support youth in “positive risk-taking,” sharing in meetings, talking to people, meeting new people, asking for help, and asking for sponsors (Passetti & Godley, 2008). Participating in youth mutual aid support groups improves treatment outcomes (Kelly, Dow, et al, 2010; Kelly, Stout, & Slaymaker, 2013, 2014; Kelly & Urbanoski, 2012; Kingston et al, 2015).
<input type="checkbox"/>	Youth with past religious affiliation have higher assimilation rates in 12-step programs. Youth with little to no past religious affiliation assimilate less well into the 12-step community (Kelly, Myers, & Rodolico, 2008). Youth peers support and affiliate individuals with many pathways to recovery, including, but not limited to, secular, spiritual, and religious recovery mutual aid groups and other recovery-friendly social support activities. Some of these include: event/activity-based recovery (primary focus is on clean and sober activities and events, such as campouts, dances, parties, etc.), 12-step meetings, Wellbriety, SMART recovery, mindfulness yoga or groups, Celebrate Recovery, etc.
<input type="checkbox"/>	“Service work” (helping others, supporting recovery advocacy and recovery support and celebration events, and performing acts of community service) gives youth meaning and purpose in social gatherings and events and assists them in having a reason for being there. Service work empowers youth to take

	responsibility for the outcomes of social gatherings, meetings, and events. Service work is made available to those with a wide spectrum of skills and aptitudes. Skilled service work may be posting announcements/updating a website which would require knowledge of web software like Wordpress, HTML5, MODO, Joomla, etc. Unskilled service work may include making coffee, orienting new participants to the facility and services, or orienting newcomers to available recovery meetings and events. Youth peer programs ensure all participants can contribute, utilizing their assets.
<input type="checkbox"/>	Youth peer programs assist youth in becoming leaders, through advocacy training, participating in advocacy events, assuming responsibilities, and helping others. Leadership empowers youth to assume more responsibilities in addition to claiming ownership within the youth recovery community.

**Best Practice Five: Facilitating Event/Activity-Based**

**Recovery.** SUD youth peer services are activity-based. Youth peer recovery groups have a long history of prosocial events and recreational activities dating back to the 1940’s. In the 1940’s, Alcoholics Anonymous’ groups for persons 35 and under formed in metropolitan areas around the U.S. In 1952, Riverside Hospital began the first treatment center dedicated to adolescents and included recreational activities as a part of their programming. In 1958, the International Conference of Young People in Alcoholics Anonymous (ICYPAA) was founded, producing area and national conferences typically hosting: dances, parties, comedy shows, open mics, etc. Several research studies on adolescent treatment and Alternative Peer Groups (APG’s) highlight the importance of prosocial and recreational activities as a part of youth recovery programs (Collier, et al, 2014; Morrison & Bailey, 2011; Nash, 2013; Nash & Collier, 2016; Nash, Marcus, et al, 2015).


 <b>Self-Assessment Checklist ✓</b>	
<b>Best Practice #5: Facilitating Event/Activity-Based Recovery</b>	
<input type="checkbox"/>	Youth-directed activities are planned and produced by youth, e.g., art groups, video games, board games and recreation at the facility. Events include, but are not limited to: dances, karaoke, comedy night, open mic, poetry readings, speaker events, battle of the bands, BBQ’s, sporting events, trips for recreation or recovery conferences, and advocacy events like going to the state capital or county commission meetings, etc.
<input type="checkbox"/>	Youth peer staff maintain a list of upcoming activities, posting event flyers in visible places, including social media.
<input type="checkbox"/>	Youth peer staff effectively utilize activities and events to facilitate skill development, including, but not limited to: positive risk-taking, social skills, communication skills, problem-solving, critical thinking, leadership skills, anger management, group facilitation, etc.
<input type="checkbox"/>	Youth peer staff effectively incorporate recovery goals and skill building into events and activities for the youth they serve as well as document the relationship of the activities and events with specific meaningful skills and recovery goals.



<input type="checkbox"/>	Youth peer staff utilize appropriate client billing mechanisms, respecting the limitations of reimbursement for activities and events. Youth peers are cognizant of their obligations to be good stewards of taxpayer dollars and to always avoid any semblance of waste, fraud or abuse. Many youth peer programs engage in private fundraising to pay for special trips and events that exceed the parameters of Medicaid/Block grant or other publicly funded youth peer services.
--------------------------	---

**Best Practice Six: Use of Technology in the Recovery**

**Community.** SUD youth peer services rely heavily on technology, including, but not limited to: texting, email, Facebook, Twitter, Snapchat, Instagram, homepages, meeting and resource directories, ACHES, Sobergrid, Squirrel, online surveys, etc. Surveying youth through technology is an important feature of “ownership” in youth peer services. Electronic surveys of youth participants allow everyone a voice in the direction of services, events, aesthetics/branding, policies, purchases (games, food), etc.

 <b>Self-Assessment Checklist ✓</b>	
<b>Best Practice #6: Use of Technology in the Recovery Community</b>	
<input type="checkbox"/>	Peer staff are aware of HIPAA compliant technology and potential threats to confidentiality.
<input type="checkbox"/>	Peer staff obtain written consent to communicate with individuals through insecure platforms.
<input type="checkbox"/>	Peer staff encourage individuals to consider the risks and benefits of their self-disclosures through: apps, email, texting, Facebook, social media and other forms of electronic communication.
<input type="checkbox"/>	The program implements electronic surveys of youth participants to empower youth voices and encourage ownership and involvement in the community decision-making process. In traditional behavioral health, surveys are typically implemented post-treatment, whereas youth peer services implement frequent electronic surveys during the course of participation in the peer program.

## Review of Recovery Apps

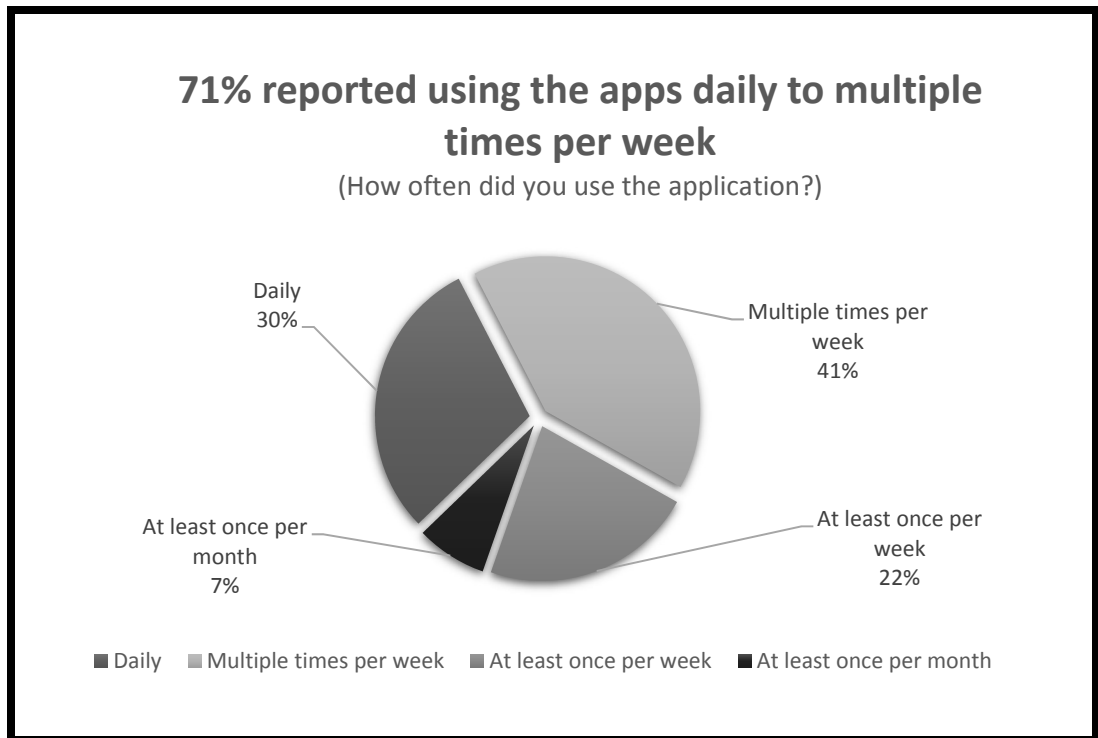
As a part of this best practices curriculum, we conducted a qualitative review of several “Recovery Apps” that contain social connectivity. These “Recovery Apps” focus on four major components:

Four Major Components of Recovery Apps			
Social Connectivity	Accomplishments	Analytics	Resources
Users are able to communicate in groups or privately with similar individuals, through the app, to give and receive support for ongoing recovery. Users are able to post, give and receive feedback on postings.	Users can measure their success with abstinence or reduced use through a “recovery counter.” Users can also make goals and see their accomplishments when goals are met. One app (A-CHESS) had a medication feature that allows participants to schedule reminders to take medications.	Users can observe patterns in behavior, feelings, moods, cravings etc. of which they may be unaware, related to their substance use, or other correlated behaviors including geographical hotspots, treatment compliance, etc.	Users can look up resources, and meetings through a “meeting finder.” Users can view recovery-oriented literature, and receive daily messages and affirmations.

In our qualitative review, 60 participants were asked to give their assessment of the pros and cons of four recovery applications that included a combination of the four major components (social connectivity, accomplishments, analytics and resources). It is important to mention the A-CHESS app has a social connectivity feature that requires administrative oversight. Whereas, the other apps use an “open social connectivity” format where users can connect with no administrative oversight. Other apps that are interactive, but do not contain much, if any, social connectivity, were not reviewed, these include: Sober Time -Sobriety Counter, Sober Tool, Clean Time App, Quit Drug/Porn/Food Addiction, No More Quit Your Addictions, Recovery Elevator, Sobriety Counter – Stop Drinking, N.A. 12 Steps App, Sobriety Clock, Sobriety Calculator, nomo – Sobriety Clocks, Day Counter. Additionally, there are other non-social apps whose primary function is to provide recovery literature, daily affirmations/messages to users. Sixty youth from the 4<sup>th</sup> Dimension Youth Recovery Center participated in our qualitative review of four interactive social apps:’

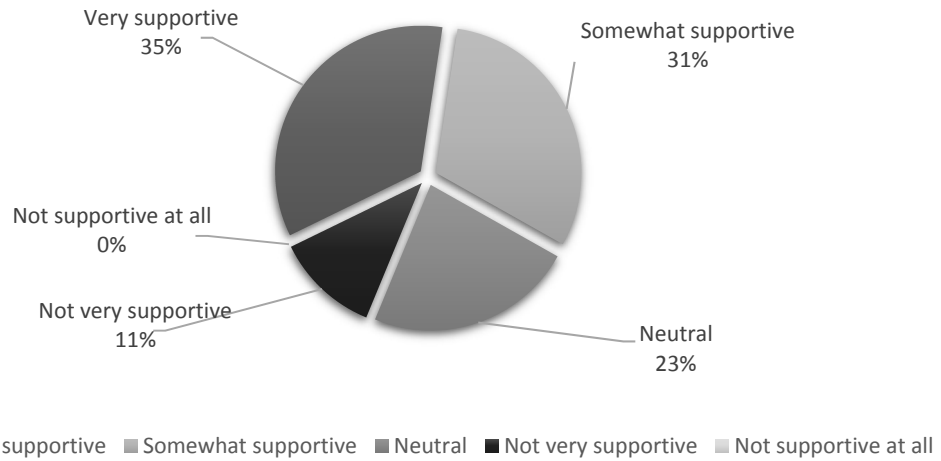
- A-CHESS
- Sober Grid
- A Recovery Facebook Group
- Squirrel Recovery

Of 60 participants, 28 completed the qualitative review post-evaluation. Many participants lost interest and chose not to complete the review and the post-evaluation, a few were experiencing homelessness and were not available for the post-evaluation, likewise a few others were unavailable due to incarceration or placement in addictions treatment.



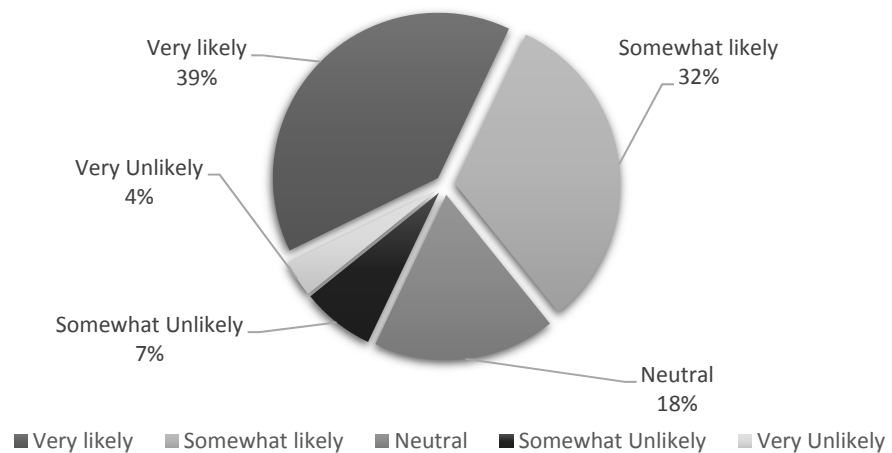
## 66% felt the apps were very or somewhat supportive of their recovery

(Do you feel this app was supportive of your recovery?)



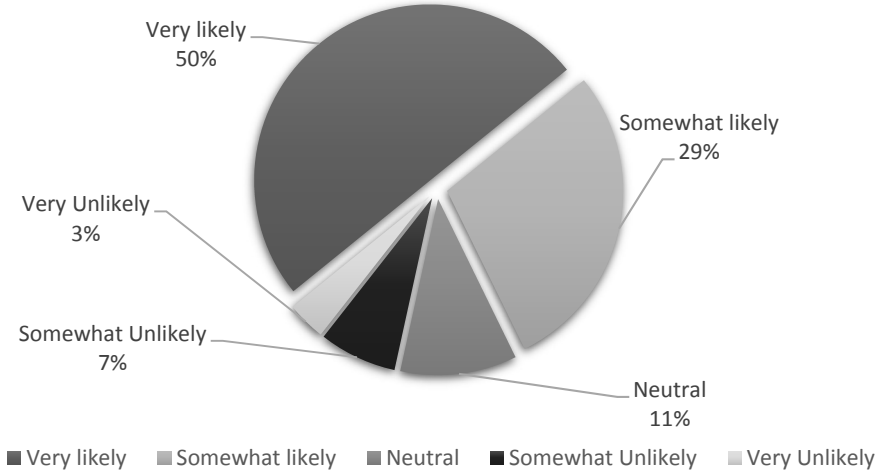
## 71% reported they are very likely to somewhat likely to continue using the apps

(On a scale of 1-5 how likely are you to continue using the app?)



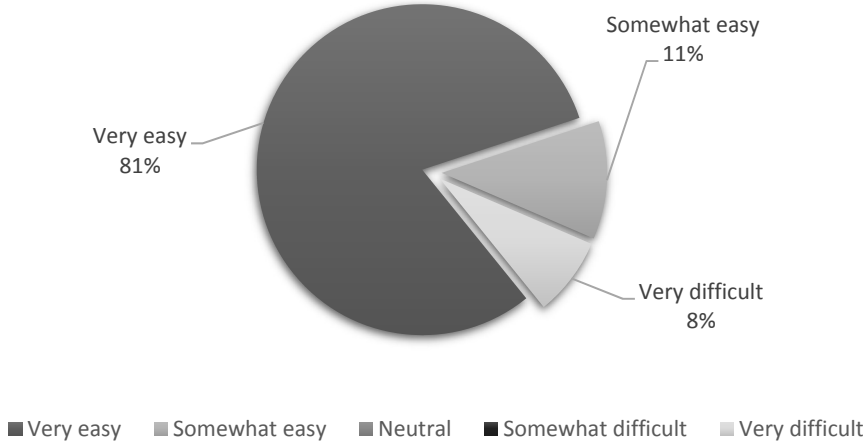
**79% reported they are very likely or somewhat likely to refer other youth to the app**

(On a scale of 1-5 how likely are you to refer others to this app?)

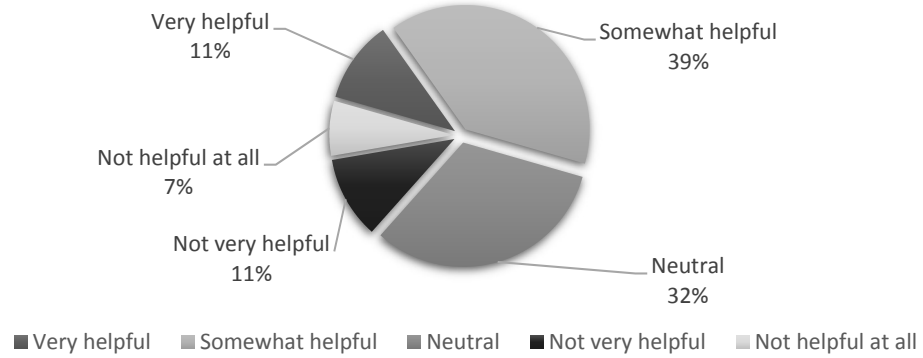


**92% reported that the apps are very easy to somewhat easy to use**

(On a scale of 1-5 how easy was it to use and understand the app?)



**50% reported the apps are very to somewhat helpful in reducing cravings**  
 (On a scale of 1-5 how helpful was this app in reducing cravings?)



**A qualitative review of four recovery apps**

<p><b>A-CHESS</b></p>	<p>A-CHESS is an application designed to provide ongoing support and relapse prevention to people recovering from substance use disorders during and after treatment. A-CHESS is an evidenced based application on the SAMHSA NREP registry. A-CHESS includes: social connectivity, a recovery counter, analytics, and motivational messages, medication and appointment reminders, recovery planning and journaling functions, a caregiver dashboard including a relapse warning system, geo-fencing of high risk locations and the capacity for caregivers to distribute customized content to individuals or groups as well as custom clinical or non-clinical surveys to individuals or groups.</p>	<p><b>PROS:</b> Participants liked the daily check-in and goals creation features. The app also reminds you of things without having to open the app. Others appreciated the inspirational quotes and daily survey. One participant said the best part was the feature that allowed him to schedule his medication times.</p> <p><b>CONS:</b> More easily loads on android phones, but difficult to load onto an apple iPhone. Some Apple users reported difficulty loading the app at start up.</p> <p><b>YOUTH PEER STAFF COMMENTS:</b> This is a great app for individuals participating in addictions treatment. This structured app contains powerful analytics that we were unable to use during the short course of this product review. This app may be less suited for drop-in recovery centers that specialize in youth peer support versus a structured addictions treatment program, because it requires some administrative oversight.</p>
-----------------------	---	---

<p><b>Sobergrid</b></p>	<p>Sober Grid is a free iOS/Android app that GPS connects you with other sober people. You are instantly connected to a global sober community in your neighborhood and around the world. You can build strong sober support networks and inspire others.</p>	<p><b>PROS:</b> Participants really enjoyed the Newsfeed and social connectivity of this app. They also appreciated the meeting finder and recovery readings.</p> <p><b>CONS:</b> Two participants wished there was a way to post video to the newsfeed.</p> <p><b>YOUTH PEER STAFF COMMENTS:</b> This app is recommended for post-treatment social support as it mirrors other popular social media apps (Facebook, Instagram and twitter), and is a wise choice for youth peer support programs, especially because it is free.</p>
<p><b>Squirrel</b></p>	<p>Squirrel Recovery Addiction App is personalized to each user. It sets up a recovery circle with sober support people of your choice. You can set personal check-in times for the app to check-in when using was most likely to occur. This information will be sent in a text message to people you have chosen to be your recovery circle. A Panic button bypasses all check-ins so that help can be given immediately. Squirrel Recovery Addiction App also keeps track of sober days, gives "coins" when milestones are achieved and offers motivational quotes of encouragement.</p>	<p><b>PROS:</b> Participants liked the daily check-in, the daily planner, the social connectivity, recovery reading, and mindfulness techniques. Participants enjoyed the texting features within the app. Users also appreciated the analytics and reporting on "how you are doing."</p> <p><b>CONS:</b> Some felt that the app could include more features like a meeting finder. Some reported that the app was sometimes "glitchy."</p> <p><b>YOUTH PEER STAFF COMMENTS:</b> The app requests that you enter information regarding multiple sponsors and many of the participants were confused because most 12-Step participants have only one sponsor. Some who were new to recovery, asked if they needed multiple sponsors.</p>
<p><b>Facebook Closed Group</b></p>	<p>Our Facebook group was a "closed group," meaning only the administrator could add or delete members from the group. Participants were given loose guidelines for posting content: recovery related events, 12-step meetings; participants were encouraged to post recovery milestones: clean and sober time,</p>	<p><b>PROS:</b> Participants enjoyed learning about a smaller group of recovering young people within the greater recovery community. They enjoyed the Newsfeed and posting. They very much enjoyed the connectivity.</p> <p><b>CONS:</b> One participant reported that this style of social connectivity did not reduce their cravings to use, and another was disappointed in the lack of responsiveness</p>

	reunification with family and friends, employment and education success and anything else they felt positive about; participants were also encouraged to “reach-out” when they felt their recovery may be in jeopardy. For safety reasons, participants were informed if they harassed other members, they would be removed from the group.	from individuals within the group.  <b>YOUTH PEER STAFF COMMENTS:</b> This type of recovery oriented social media support is imperative as many young people use Facebook. Since the conclusion of the survey, and at the request of the participants, the Facebook group now allows other young people in recovery to join. Since concluding the review, more than 25 young people in recovery have been added to the Facebook group.
--	---	--

## Summary

Both youth in general and youth peer services heavily utilize technology. In this review, nearly half the youth lost interest in participation. Youth peer staff were concerned that recovery oriented apps may have a difficult time competing with the largest and most popular mainstream social media platforms: Facebook, Instagram, Twitter and Snapchat. Of the 47% who remained in the technology review, insights were offered regarding the pros and cons of each app. Most notably, individuals were often disappointed on the lack of immediate response to posted communications. For example, individuals may “log on” only to find that no other participants were “logged on” (live) at the same time or other individuals had not responded to their post’s. When an individual logs onto Facebook, Instagram, Twitter and Snapchat, invariably there are others who are logged on and responsiveness to post are often instantaneous. This may also account for the low rating participants reported regarding the capacity of these recovery apps to reduce craving (50%). If an individual logs on for support while having impulses to use substances, only to find no one is online, this would not provide support when the individual needs it the most. This is concerning for newly recovering individuals heavily involved in the four major social media platforms (Facebook, Twitter, Instagram and Snapchat) because some research reveals a strong association between alcohol and drug use and the density of online social activity, especially in males (Cook, et al, 2013; Ohannessian, 2009).

Research on the efficacy of recovery apps for youth remains limited, but existing studies show great promise for these applications as adjuncts to treatment services, such as A-CHESS, and as recovery support tools for youth in the broader recovery community and peer services (Champion et al, 2013; Gonzalez & Dulin, 2015; Gulliver et al, 2015; Marsch et al, 2007; Schwartz et al, 2014; Thombs et al, 2007; Wodarski et al, 2012).

Recovery apps are sure to evolve and adapt over time, will continue to be a part of the youth recovery movement and will need to address a lack of immediate responsiveness/support for individuals in crisis. Youth peer programs endeavor to build recovery communities. Similarly, building an active ever-present online recovery community is equally important and presents different challenges. These applications also present challenges for confidentiality in publicly funded youth peer delivered service programs, especially with applications that are not HIPAA



compliant. Peer programs that utilize insecure social media should develop internal policies regarding their use and often have participants sign “Informed Consent – Electronic Release(s)” that inform individuals about the risks and benefits of participating in these electronic communications.

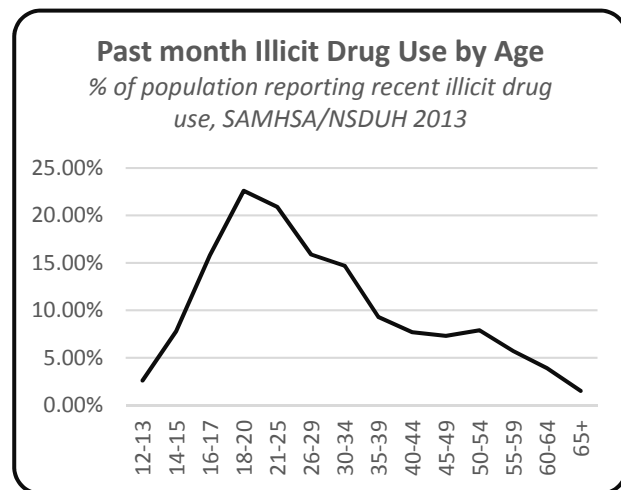
See Appendix Two for a sample “Social Media/Electronic Communication: Informed Consent and Release.”

## Section Three: SUD Youth Peer Services

### ✓ **Best Practice Seven: Screening Transition Age Youth for SUD**

**Peer Services.** Screening youth for appropriateness of services is an important aspect of SUD youth peer programs. For example, 18-20 year olds have the highest rate of substance use and many experience emotionally-driven episodes of excessive substance use that would not necessarily meet the diagnostic criteria for a severe substance use disorder (addiction).

SUD youth peer programs are dedicated to addiction recovery, and must be able to screen participants to maintain their primary mission and purpose of striving towards abstinence (Ridenour et al., 2012). Many allied behavioral health professionals have a difficult time understanding the distinction between episodic emotionally-driven substance use, and chronic addiction often driven by tolerance and withdrawal.



Many substance-involved youth present with an array of issues, including family discord, risky behaviors, difficulty with emotional containment, academic or occupational problems, etc. Yet, many of these young people don't meet the diagnostic criteria for a severe substance use disorder, do not identify as being addicted to drugs and/or alcohol, and may age out of excessive substance use (White, H. R., et al, 2005). Youth SUD peer programs primarily focus on abstinence and "addiction recovery" and solicit referrals from adolescent and young adult addiction treatment programs. Other types of youth programs that are primarily offering mental health peer support often focus on substance use prevention and/or reducing substance abuse rather than an explicit focus on addiction recovery. Both types of youth peer programs are important and necessary in addressing the continuum of youth substance use. However, youth programs that are dedicated to "addiction recovery" must be able to screen participants for severe substance use disorders to maintain the focus on the primary mission of striving towards abstinence, including abstinence from alcohol and illicit drugs while participating in medication-assisted recovery. The Stacie Mathewson Foundation: *Transforming Youth Recovery* makes a clear distinction between youth peer programs that offer prevention, intervention, and recovery.

Oftentimes this division between youth peer services is difficult for allied health providers to understand. It is especially difficult for behavioral health professionals, who are not in recovery from addiction themselves, to clearly comprehend this division. SUD peer programs that are designed to offer peer support for individuals in recovery from addiction have the primary purpose and mission of striving toward abstinence and helping others achieve abstinence, including abstinence from alcohol and illicit drugs while participating in Medication Assisted Recovery. These “addiction recovery” peer programs often host or facilitate addiction recovery support groups like: 12-step groups, Wellbriety meetings, SMART, SOS, etc. that also focus on addiction recovery.

**Differentiated Table of Youth SUD Peer Program vs Youth Mental Peer Program**

<b>Type of Youth Program</b>	<b>Target youth group</b>	<b>Goal of services</b>
<b>Youth Mental Health Peer programs</b>	<ul style="list-style-type: none"> <li>• Youth with mental and emotional challenges who present episodic or occasional excessive alcohol and/or drug use.</li> <li>• Their use of drugs and alcohol is largely driven by emotions, and is more episodic vs. chronic, with little to no prior attempts to quit or cut down.</li> </ul>	Strive to reduce, contain, or stop substance use and self-medication of mental and emotional difficulties, oftentimes focusing on the emotions that fuel excessive substance use.
<b>Youth Addiction Peer programs</b>	<ul style="list-style-type: none"> <li>• Youth addicted to alcohol and/or drugs, who have chronic use, and meet the diagnostic criteria for a severe substance use disorder.</li> <li>• History of early onset use (Van Ryzin &amp; Dishion, 2014).</li> <li>• Their substance use is driven largely by craving, tolerance and withdrawal, and is more chronic vs. episodic, with numerous prior attempts to quit or cut down.</li> <li>• These individuals chronically use substances without regard to their emotional states (happy, sad, joyful, depressed, angry, content, etc.).</li> </ul>	Strive to abstain from alcohol and illicit substances and develop coping skills to avoid relapse.

## Why do we need to separate substance users into two distinct groups?

As previously mentioned, they have differing goals. Moreover, some research suggests that referring youth with low severity substance use disorders to programs that cater to youth with high severity substance use disorders (addiction) can have negative impacts on the youth with low substance use, possibly increasing their rate of substance abuse to mirror that of the more severely addicted participants. Additionally, rates of comorbid tobacco addiction are much higher in addicted populations. Research reveals that including youth with low-levels of substance-related problems (including low level tobacco use) into youth groups with higher levels of addiction (including much higher tobacco use) often leads to increased tobacco consumption in those more naïve groups of youth.


Screening questions are typically designed to establish the individual has a substantial substance use history within the context of their age, prior addiction treatment history and that the individual has had prior attempts to quit or cut down on their use. Additionally, screening questions attempt to assess an individual’s medical stability to determine if withdrawal management services, infectious disease testing, or other medical or emergency services are needed. Screening instruments and interview protocol are strengths-based—focusing on assets as well as challenges.

### 4<sup>th</sup> Dimension Recovery Center


“We get a lot of teen and young adult referrals. Some of the youth referred to our recovery center have only used alcohol or drugs a few times. Some mental health professionals, who don’t understand peer support and the value of lived-experience, think, *‘Well, I know you’ve only used a few times, but I think it would be good for you to be with sober kids.’* This is an innapropriate referral. 4<sup>th</sup> Dimension is a recovery center for youth with similar lived-experience who support each other in addiction recovery.” - Tony Vezina, Director 4D

### Screening questions

1. Are you currently in addiction treatment, including medication assisted treatment? Have you been in addiction treatment in the past? Have you currently been attempting to get into addiction treatment?
2. Can you tell me about your current alcohol and drug use? Your use in the past?
3. Have you tried to quit or cut down in the past?
4. Are you having any current health problems related to your alcohol or drug use?
5. Are you currently in withdrawal or do you anticipate going into withdrawal?
6. Do you think that you have a problem with drugs/alcohol?


 <b>Self-Assessment Checklist ✓</b>	
<b>Best Practice #7: Screening TAY Youth for SUD Peer Services</b>	
<input type="checkbox"/>	Youth peers have an established set of screening questions and criteria for admission into peer services.
<input type="checkbox"/>	Youth peers can couple screening questions with open-ended questions to elicit qualifying criteria.
<input type="checkbox"/>	Youth peers are knowledgeable regarding signs of medical distress, associated with chronic alcohol or drug use that warrant referral to primary care, public health, the emergency department or withdrawal management services.
<input type="checkbox"/>	Youth peer programs establish the nature of SUD services being offered: prevention, intervention or recovery support.
<input type="checkbox"/>	The program has considered issues regarding the “mixing” of adolescents and young adults and has implemented adequate safety precautions and policies. The program informs participants regarding the age ranges of individuals being served. Moreover, the program requests that adults 18 and older not share tobacco, or nicotine products with minors, and ask minors not to request tobacco or nicotine products from those 18 or older. In some states, 21 is the legal age for consumption of tobacco products.

**Best Practice Eight: Embrace Diversity, Inclusivity & Individuality through the Primary Mission.** SUD youth peer services have diverse participants with a wide variation in recovery capital compared to traditional behavioral health care organizations. Traditional behavioral health care agencies tend to be more stratified by specialty services with funding streams that lead to more economically homogenized clients (for example: residential treatment for low-income women with children involved in child welfare, or specialty treatment for affluent and employed licensed professionals with private insurance). SUD youth peer services have participants ranging from stable teens and young adults with supportive affluent families to homeless teens and young adults with little to no resources or family support. Moreover, youth peer programs embrace racial and ethnic diversity, LGBTQ2I individuals, unconventional youth, those with mental health challenges, and those with varying disabilities (Quality Indicator 7&8, CSAT, 2006). As a result, the latter programs develop policies and practices to ensure equality, equity, and safety for all participants. The challenges of inclusivity are overcome through an unrelenting focus on the primary mission of SUD recovery.

 <b>Self-Assessment Checklist ✓</b>	
<b>Best Practice #8: Embrace Diversity, Inclusivity &amp; Individuality through the Primary Mission</b>	
<input type="checkbox"/>	Youth peers understand the diversity of the youth participating in the program.
<input type="checkbox"/>	Peer staff understand the wide range of peer services (resources, support, linkages, etc.) needed for individuals with varying amounts of recovery capital.
<input type="checkbox"/>	Challenges inherent with inclusivity are overcome by maintaining focus on the primary mission of SUD recovery. The singularity of purpose (addiction recovery by any means necessary) binds diverse individuals together in common cause. Alternative pathways and styles of recovery are expected and respected. Youth peers are encouraged to respect multiple pathways and styles of recovery initiation and maintenance.
<input type="checkbox"/>	Peer programs develop policies to ensure the safety of diverse individuals. For example, “no hate speech,” “no financial exploitation of those with financial resources,” or “no sexual exploitation of those with little to no resources.”
<input type="checkbox"/>	Peer programs incorporate continued training and education specific to various diverse populations: LGBTQ2I, gender identity, race and ethnicity, disabilities, etc.

**Best Practice Nine: Person-centered and Trauma-informed**


**Care.** Youth peer programs are youth-centric employing “youthful persons in recovery” who are trained and prepared to offer person-centered/directed services. Many youth with addiction have already experienced involuntary commitment to addiction treatment or mental health services, including forced medication, juvenile detention/probation, or other highly directive services. Subsequently, many youth are unaccustomed to person-centered and self-directed care. Staff offer their knowledge and experience, reviewing pros and cons of various life decisions, while eliciting self-directed goals from youth participants. Staff are trained to offer trauma-informed services to traditionally marginalized, oppressed, and stigmatized populations (cultural/ethnic minorities, LGBTQ2I youth, those with addiction & mental health challenges, those with varying disabilities). Staff focus on strengths and resiliency vs. the diagnostic deficit model common in traditional behavioral healthcare (Humphreys & Lembke, 2013; Kaplan, 2008; Kelly & White, 2011; White, 2005, 2008a, b; White, Humphreys et al., 2013; Whitter, Hillman, & Powers, 2013).

 <b>Self-Assessment Checklist ✓</b>	
<b>Best Practice #9: Person-centered and Trauma-informed Care</b>	
<input type="checkbox"/>	Many youth with severe SUD’s have previously experienced highly directive involuntary services. A shift from directive hierarchical to reciprocal relationships can be difficult for some youth who have been institutionalized. Youth peer staff implement person-centered and self-directed services describing an array of recovery options and activities and eliciting and supporting individual choice.

<input type="checkbox"/>	Youth peers are aware of trauma often experienced by youth with severe substance use disorders, including, but not limited to: sexual assault while intoxicated, injury or theft while intoxicated, sexual exploitation associated with homelessness, and other forms of victimization. Youth peers validate these traumatic experiences, offer emotional support, and inspire hope through sharing their own stories of recovery that include recovery from traumatic experiences.
<input type="checkbox"/>	Generally, treatment research reveals that youth have lower motivation for change compared to middle aged and older adults. Youth peers are trained in motivational interviewing techniques including: “Evoke and Elicit,” ACE (Autonomy, Collaboration and Evocation), “Developing Discrepancy,” and “Decisional Balance” worksheets and discussions.
<input type="checkbox"/>	Youth peers use and model recovery oriented principles with individuals: person first language, multiple pathways, individual choice, informed consent, self-determination, empowerment, self-advocacy, fostering independence, etc. (SAMHSA/IC&RC: Peer Competencies).
<input type="checkbox"/>	Youth peers use respectful, person-centered, recovery-oriented language in written and verbal interactions with individuals they serve, family members, community members, and others (SAMHSA/IC&RC: Peer Competencies).
<input type="checkbox"/>	Youth peers assist and support individuals to set goals and to dream of future possibilities. They provide concrete assistance to youth in accomplishing goals, and then celebrate individual efforts and accomplishments. Youth peers focus steadily on short-term personal goal setting as incremental accomplishment of personal goals has been shown to counter the effects of estrangement from “old using friends” (Butman, 2009).
<input type="checkbox"/>	Youth are inexperienced regarding the normal “wait times” associated with systems and bureaucracies. Youth peer staff strive to minimize wait times for services and respond quickly to youth in need of services.
<input type="checkbox"/>	Youth peers offer education and resources that are relevant and appealing to youth, including infectious disease and sexual health education and resources. Youth peers support individuals in referrals to public health and infectious disease testing, including accompanying youth to appointments for testing and obtaining results of infectious disease testing.
<input type="checkbox"/>	Youth peer services are low-cost and affordable, including events and activities. While services are often funded through grants and healthcare dollars, activities and events are not.

**Best Practice Ten: Intensive Contact Post-treatment.**


Contemporary treatment research reveals that youth are at greatest risk of relapse within 30 days post-treatment, and that post-treatment recovery support activities significantly reduce a return to substance use and related problems (Chung & Maisto, 2006). Youth peers strive to meet individuals at their treatment agencies prior to discharge (warm hand off) and engage in assertive outreach with individuals post-treatment.

 <b>Self-Assessment Checklist ✓</b>	
<b>Best Practice #10: Intensive Contact Post-treatment</b>	
<input type="checkbox"/>	Youth peers initiate contact with individuals across the continuum of recovery: pre-treatment, concurrent treatment, post-treatment. Youth peer staff provide assertive outreach to those transitioning from addiction treatment to ensure better outcomes (Passeti & Godley, 2008).
<input type="checkbox"/>	Youth peers prioritize admission and services to those exiting addiction treatment services. SAMHSA's Role of Recovery Support Services in ROSC [Recovery Oriented Systems of Care], states, "Research found that those who participated in both treatment and recovery support had better long-term outcomes than people who used either service alone."
<input type="checkbox"/>	Youth peers use multiple media in the delivery of post-treatment recovery support services. Post-treatment recovery support activities and schedules vary by problem severity, recovery capital, and by variations in recovery stability over time. The need for recovery management checkups and the duration of checkups varies by problem severity/complexity and level of recovery capital, and should be provided on a mutually agreed upon schedule rather than provided on a fixed schedule to all recipients of such services.
<input type="checkbox"/>	Voluntary recovery checkups are maintained as long as desired by program participants. This long-term commitment to providing recovery checkups may be confounded by grant/funding protocols requiring "discharge" of individuals for the purposes of data evaluation. Currently peer services are struggling with the traditional linear model of ASAM-driven care that moves from intensive services to lower levels of care to eventual discharge—all over what is historically a decreasing period of time. Peer services are more consistently non-linear, with individuals needing minimal contact, only to then experience a crisis requiring significant peer contact, only to return to minimal needed contact in the following weeks. Real life and real recovery requires not a fluid declining level of service, but accessibility of support that is sustained and adaptable to changing circumstances. Where traditional treatment services may last 90-120 days on average, peer service contact may occur over a period of years.
<input type="checkbox"/>	Youth peers avail themselves to "warm hand offs," by going to treatment agencies and meeting with youth actively enrolled in treatment and soon-to-be graduates prior to the termination of treatment services (Tracy, et al, 2011). Youth peer services can effectively enhance the likelihood of treatment completion and maintenance of gains achieved during treatment.
<input type="checkbox"/>	Youth peers consistently and redundantly provide information about upcoming events and activities to program participants.
<input type="checkbox"/>	Youth peers established rehearsed mechanisms to introduce, orient and include new individuals into the greater youth recovery community.



**✓ Best Practice Eleven: Supporting Self-management of High Risk Social Groups.**

Research reveals that youth are more heavily influenced by their social relationships and peer groups, compared to middle-aged and older adults. Resumption of drug use, including return to chronic substance-related problems, is associated with drug-using peer influences. Youth peers assist and support individuals in enhancing their own recovery environment and self-directed endeavors to avoid high-risk peer groups, risky hangouts and self-management of challenging family circumstances (Andrews et al., 2002; Chung & Maisto, 2006; Duncan et al., 2011; Fisher et al., 2007; Hong et al., 2013; Reboussin et al, 2012).

 <b>Self-Assessment Checklist ✓</b>	
<b>Best Practice #11: Supporting Self-management of High Risk Social Groups</b>	
<input type="checkbox"/>	Youth peers demonstrate skills in motivational enhancement, understand the stages of change, and demonstrate the capacity to engage individuals in “quit talk,” give affirmations, develop discrepancy, and honor the individual’s self-efficacy, self-determination, and individual choice. (SAMHSA, ICRC)
<input type="checkbox"/>	Youth peer staff support individuals in changing their peer groups. Youth peers do not make attempts to exclude “old using friends,” rather they support individuals in becoming more inclusive of peers in recovery. Youth peers use motivational techniques in assisting individuals in assessing the “relapse potential or safety” of various peer influences (Dingle et al., 2015). Youth often have low motivation to reduce contact with substance-using peers despite having high motivation for abstinence (Chung et al., 2015). Therefore, youth peers must utilize motivational techniques and open-ended questions to facilitate reflection regarding high-risk situations.
<input type="checkbox"/>	Similarly, youth peers do not make attempts to exclude substance using family members, rather they support individuals in becoming more inclusive of peers in recovery and creating a “recovery family” within the recovery community. Youth peers use motivational techniques in assisting individuals in assessing the “relapse potential or safety” of various family members or family events/celebrations. For example, sometimes youth are encouraged to visit with family in the morning vs. evening, when individuals are less likely to be consuming alcohol or other drugs.
<input type="checkbox"/>	Youth peers validate and normalize the quandary of reducing their social contacts with others who are actively using alcohol and drugs (SAMHSA/IC&RC: Peer Competencies). Youth peers do not dictate rules to individuals regarding who they may or may not associate with. Rather, they share their experiences regarding recovery and their experiences disengaging with individuals who “actively” use alcohol and drugs.
<input type="checkbox"/>	Youth peer staff assist individuals in locating safe clean and sober housing. Youth peers are knowledgeable regarding youth-friendly housing options and availability (Kendler, 2015). While lacking any substantial research, youth-friendly and youth-oriented recovery housing has been reported to be effective and may need additional staff to support youth in youth-only sober housing (Goldman, 1986; Berman et al, 2015; Polcin et al, 2015).

**✓ Best Practice Twelve: Employment, Education & Housing.**

Youth peer staff support young recovering individuals in developing a plan for living that includes education, vocational training and/or employment. Research regarding youth employment post-treatment is mixed. While most treatment-related research suggests that employment is a major factor in ongoing recovery post-treatment, some research indicates that among youth, full-time employment post-treatment is associated with higher rates of relapse (Godley, Passetti, & White, 2006). There are a variety of reasons why this might be true. Youth leaving addiction treatment who immediately begin working full-time might be less invested in developing a recovery support program and network and now have a significant amount of disposable income from their full-time employment. Youth peer mentors assist individuals in assessing the pros of cons of education and vocational training vs. immediately entering the workforce.

<b>Self-Assessment Checklist ✓</b>	
<b>Best Practice #12: Employment, Education &amp; Housing</b>	
<input type="checkbox"/>	Youth peers support individuals in making choices regarding employment, education and growth opportunities. Some employment has significant growth and advancement opportunities, while many jobs do not.
<input type="checkbox"/>	Youth peers support individuals who choose to find employment with referrals to companies where recovering individuals work, felony-friendly employers, and industries with lower rates of substance-related problems among their employees.
<input type="checkbox"/>	Youth peers assist individuals in contemplating their occupational growth opportunities, career ladder, on-the-job training programs, vocational training programs, and orientation to colleges and universities. Youth peers also describe opportunities for training and education combined with part-time employment.
<input type="checkbox"/>	Youth peers understand college enrollment, entrance exams and assist individuals with scholarship, grant, and student loan applications.
<input type="checkbox"/>	Youth peers are knowledgeable regarding an array of vocational training opportunities and know when and where those opportunities occur.
<input type="checkbox"/>	Youth peers participate in maintaining up-to-date information about community resources and services specific to transition age youth.

**✓ Best Practice Thirteen: System Navigation: Supporting the Inexperienced.**

Youth peers understand that most young people do not always know or understand complex bureaucratic systems (banking, criminal justice, child welfare, health care/Medicaid, colleges, vocational training, TANF, SNAP, housing agencies, addiction treatment, mental health, etc.). Youth peers educate and assist in orienting individuals to the culture, rules, and opportunities within varied systems.

Self-Assessment Checklist ✓	
Best Practice #13: System Navigation: Supporting the Inexperienced	
<input type="checkbox"/>	Youth peers orient individuals to various systems and let them know what to expect in the process (criminal justice, child welfare, health care/Medicaid, colleges, vocational training, TANF, SNAP, housing agencies, addiction treatment, mental health, etc.). Where many adults may have prior experiences with systems, feeling frustrated or forgotten, many young people have no experience with these systems what-so-ever. Youth peers incorporate “orientation to systems” into systems navigation by assisting individuals in setting up appointments, accompanying individuals to appointments, and filling out paperwork.
<input type="checkbox"/>	Youth peers engage and advocate for individuals within systems to ensure that they fully understand those systems, receive appropriate services, are treated fairly and that they voice any questions, concerns or objections they may have. Youth peers empower individuals through a three-step process: <ul style="list-style-type: none"> <li>• Step One: It’s OK to ask questions</li> <li>• Step Two: It’s OK to express your concerns</li> <li>• Step Three: It’s OK to voice your objections</li> </ul>
<input type="checkbox"/>	Youth peer staff can often be less educated in system navigation themselves due to their own lack of experience. Programs prioritize resources and system navigation during supervision to ensure the staff achieve systems literacy.
<input type="checkbox"/>	Youth peers convey the individual’s point of view when working with colleagues (SAMHSA, IC&RC: Peer Competencies).
<input type="checkbox"/>	Youth peers partner with community members and organizations to strengthen opportunities for the individuals they serve (SAMHSA, IC&RC: Peer Competencies).

✓ **Best Practice Fourteen: Boundaries & Role Ambiguity**

**Inherent in TAY Peer Services.** Youth peers understand their professional, ethical and legal obligations. Youth peers acknowledge that boundaries between peers and individuals receiving services must be managed for the safety of the individual, program and environment. Youth peers who share the same recovery social networks do not compromise confidentiality and the integrity of services, while remaining cognizant of competing interests.

Self-Assessment Checklist ✓	
Best Practice #14: Boundaries & Role Ambiguity Inherent in TAY Peer Services	
<input type="checkbox"/>	Youth peer programs incorporate training in ethics, boundaries and legal obligations. Youth peers are trained about differences between the role of peer mentor, counselor, and recovery mutual aid sponsor. Relationship boundaries and problems related to role ambiguity and role conflict are addressed in supervisory meetings.
<input type="checkbox"/>	Youth peers comply with organizational policies regarding peer-individual practices and relationship boundaries, social media rules, financial policies, smoking policies, etc. Youth peers are equitable and just and do not exercise favoritism (SAMHSA/IC&RC: Peer Competencies).

<input type="checkbox"/>	Youth peer supervision prioritizes time to discuss the use of technology and incorporate appropriate social media etiquette and understand HIPAA compliant applications/programs.
<input type="checkbox"/>	Youth peers encountering and engaging with the families of individuals they serve, provide education regarding the nature of addiction and recovery. They support families and support conflict resolution and communication while adhering to both client confidentiality laws and the wishes of the individuals.
<input type="checkbox"/>	Youth peers often interact with family members of adolescents and young adults. Youth peers offer a substantial amount of education regarding the full spectrum of alcohol and other drug problems to parents/guardians and other family members. Youth peers spend a significant amount of time interacting with parents/guardians compared to general adult peer services. Youth peers do not act as family therapists, nor do they collude with youth against their parents/guardians. Youth peers maintain confidentiality within the limits of state law. HIPAA guidelines defer to state law pertaining to the disclosure of information regarding adolescents to parents and guardians. Please refer to your SSA single state agency for more information regarding the confidentiality of adolescent alcohol and drug services.
<input type="checkbox"/>	Youth peers who share recovery social networks, disclose such shared relationships to ensure conflicts of interest do not compromise service integrity.
<input type="checkbox"/>	Youth peers are well trained in mandatory reporting laws and guidelines, as recent unreported child abuse is more likely to be present with youthful populations.
<input type="checkbox"/>	Youth peers, many who may be newer in recovery themselves, seek out support and consultation with supervisors to deal with role ambiguity, role conflicts, and methods of self-care (Wiebel, et al, 1993; White, 1979; White, 2009).

**Best Practice Fifteen: Maturing Recovery, Health & Wellness.**

Physical and mental health are inextricably linked and improving one can help to improve the other. Peer staff understand the importance of wellness and support individuals in developing healthy habits that incorporate the SAMSHA Eight Dimensions of Wellness.

<b>Self-Assessment Checklist ✓</b>	
<b>Best Practice #15: Maturing Recovery, Health &amp; Wellness</b>	
<input type="checkbox"/>	<b>Emotional:</b> Peer staff help individuals develop coping skills, feeling identification, and how to identify potential relapse triggers. Youth peers demonstrate the capacity to be non-judgmental and attentively listen, and reflect accurate understanding of the individual’s experiences and feelings, and clarifies their understanding of information when in doubt of the meaning (SAMHSA/IC&RC: Peer Competencies).
<input type="checkbox"/>	<b>Environmental:</b> Youth peers help individuals find safe, stimulating environments that support well-being.
<input type="checkbox"/>	<b>Financial:</b> Youth peers help individuals develop financial literacy, including simple budgeting, opening bank accounts, etc.
<input type="checkbox"/>	<b>Intellectual:</b> Youth peers recognize creative abilities, resiliency and encourage/support individuals to expand knowledge and skills. Youth peers assist individuals in obtaining educational and vocational self-directed goals.
<input type="checkbox"/>	<b>Occupational:</b> Youth peers support individuals in finding occupations that enrich

	their personal lives. Youth peers are cognizant of potential dangers of associated with full-time work at the expense of establishing a sober support network and impart their experiences to the individuals they serve. Youth peers inspire young people to explore their educational/vocational dreams and goals.
<input type="checkbox"/>	<b>Physical:</b> Youth peers support individuals in recognizing the need and benefit of physical activity, healthy foods, and sleep. Youth peers are aware of their scope of practice and do not prescribe particular diets, or other physical regimens to the extent that it would surpass their scope of education and credentialing.
<input type="checkbox"/>	<b>Social:</b> Youth peers support individuals in developing a support network that cultivates a sense of belonging and connectivity.
<input type="checkbox"/>	<b>Spiritual:</b> Youth peers support individuals in their spiritual practices and many pathways to recovery.

## References & Literature Reviews

1. Rita Chaney, MS, and William White, MA, Historical Milestones in Recovery from Substance Use Disorders among American Adolescents and Transition-age Youth (with a Particular Focus on Peer Recovery Support), compiled for the Portland Regional Facilitation Center

- 1) Addeo, E. G., & Addeo, J. R. (1975). *Why our children drink*. New York, Prentice- Hall, Inc.
- 2) Alford, G. S., Koehler, R. A., & Leonard, J. (1991). Alcoholics Anonymous Narcotics Anonymous model inpatient treatment of chemically dependent adolescents: A 2-year outcome study. *Journal of Studies on Alcoholics*, 52, 118-126.
- 3) Carrol, K.M. (1997). *Improving compliance with alcoholism treatment*. National Institute of Alcohol Abuse and Alcoholism Project MATCH monograph Series, Volume 6. Bethesda, MD: NIA.A.A.
- 4) *Conferences on drug addiction among adolescents*. (1953). (The New York Academy of Medicine). New York: The Blakiston Company.
- 5) Crothers, TD (1902). *Morphinism and narcomanias from other drugs*. Philadelphia: W.B. Saunders & Company.
- 6) Dana C. (1890). A study of alcoholism as it occurs in the Belleville Hospital Cells. *New York Medical Journal*, 51, 564-647.
- 7) De Leon, G., & Deitch, D. (1985). Treatment of the adolescent substance abuser in a therapeutic community. In *Treatment services for adolescent substance abusers*. NIDA Research Monograph, DHHS Publication No. (ADM) 85-1342. Rockville, MD: NIDA.
- 8) Dennis, M. L., Godley, S. H., Diamond, G. S., Tims, F. M., Babor, T., Donaldson, J., Liddle, H., Titus, J.C., Kaminer, Y., Webb, C., Hamilton, N., & Funk, R. R. (2004). The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment*, 27, 197-213. doi:10.1016/j.jsat.2003.09.005
- 9) Dennis, M. L., Titus, J. C., Diamond, G., Donaldson, J., Godley, S. H., Tims, F., Webb, C., Kaminer, Y., Babor, T., French, M., Godley, M. D., Hamilton, N., Liddle, H., & Scott, C. (2002). The Cannabis Youth Treatment (CYT) experiment: Rationale, study design, and analysis plans. *Addiction, Suppl. 1*, 16-34.
- 10) Fischer, L. (1874). The opium habit in children. *Medical Record*, 45, 197-199.
- 11) Foltz, A. Rev. (1891). *From Hell to Heaven and how I got there: Being the life history of a saved bar keeper, with stirring addresses on the temperance question*. Lincoln, Nebraska: The Hunter Printing House.
- 12) Gamso, R., & Mason, P. (1958). A hospital for adolescent drug addicts. *Psychiatric Quarterly, Supplement*, 32, 99-109.
- 13) Grob, G. (Ed.) (1981). *Nineteenth-Century medical attitudes toward alcoholic addiction*. NY: Arno Press.
- 14) Hubbard, S. (1920). The New York City Narcotic Clinic and different points of view on narcotic addiction. *Monthly Bulletin of the Department of Health of New York*, 10(2), 33-47.
- 15) Jainchill N, Hawke J, De Leon G, & Yagelka J. (2000). Adolescents in therapeutic communities: one-year posttreatment outcomes. *Journal of psychoactive drugs*, 32 (1), 81-94.
- 16) Kajdan, R.A., & Senay, E.C. (1976). Modified therapeutic communities for youth. *Journal of Psychedelic Drugs*, July-September, pp. 206-214.
- 17) MacKenzie, D. (1875). *The Appleton Temporary Home: A Record of Work*. Boston: T.R. Marvin & Sons.
- 18) Mattison, J. (1896). Morphinism in the young. *Atlantic Medical Weekly*, 5, 165- 167.
- 19) Mosher, J. (1980). The history of youthful-drinking laws: Implications for current policy. In: Wechsler, H. *Minimum-drinking age laws*. Lexington, Massachusetts: Lexington Books.
- 20) Musto, D. (1973). *The American disease: Origins of narcotic controls*. New Haven: Yale University Press.
- 21) Pollard, T. (1858). Use of opium in children. *Atlanta Medical and Surgical Journal*, 4, 129-134.
- 22) *Proceedings 1870-1875, American Association for the Cure of Inebriates*. (1981). New York: Arno Press.
- 23) Terry, C. E., & Pellens, M. (1928). *The opium problem*, Montclair, New Jersey: Patterson Smith.
- 24) White, W. (2014). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems.
- 25) White, W. (2016). The recovery school movement: An Interview with Dr. Andrew Finch. Posted at [www.williamwhitepapers.com](http://www.williamwhitepapers.com).
- 26) White, W., Dennis, M., & Tims, F. (2002). Adolescent treatment: Its history and current renaissance. *Counselor*, 3(3), 60-61.
- 27) White, W., & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor*, 7(2), 54-58.
- 28) Woodward, S. (1838). *Essays on asylums for inebriates*. Worcester, Massachusetts.
- 29) Wylie. S. (1990) Bounty hunting. *The Family Therapy Networker*. 14(4), 10.

2. Rita Chaney, MS, and William White, MA, Scientific and Professional Literature on Addiction Recovery/Peer Recovery Support Services (PRSS) for Adolescents and Transition Age Youth

- 1) Agrawal, A., Balasubramanian, S., Smith, E. K., Madden, P. A., Bucholz, K. K., Heath, A. C., & Lynskey, M. T. (2010). Peer substance involvement modifies genetic influences on regular substance involvement in young women. *Addiction, 105*(10), 1844-53.
- 2) Ali, M. M., Amialchuk, A., & Nikaj, S. (2014). Alcohol consumption and social network ties among adolescents: evidence from Add Health. *Addictive Behaviors, 39*(5), 918-22.
- 3) Andreas, D., Ja, D. Y., & Wilson, S. (2010). Peers reach out supporting peers to embrace recovery (PROSPER): A center for substance abuse treatment recovery community services program. *Alcoholism Treatment Quarterly, 28*(3), 326-338.
- 4) Andrews, J. A., Tildesley, E., Hops, H., & Li, F. (2002). The influence of peers on young adult substance use. *Health Psychology, 21*(4), 349.
- 5) Barber, B. L., Eccles, J. S., & Stone, M. R. (2001). Whatever happened to the jock, the brain, and the princess? Young adult pathways linked to adolescent activity involvement and social identity. *Journal of Adolescent Research, 16*(5), 429-455.
- 6) Bassuk, E. L., Hanson, J., Greene, N., & Laudet, A. (2016). Peer-delivered recovery support services for addictions in the United States: A systematic review. *Journal of Substance Abuse Treatment, 63*, 1-9. doi: 10.1016/j.jsat.2016.01.003
- 7) Bekkering, G. E., Marien, D., Parylo, O., & Hannes, K. (2016). The effectiveness of self-help groups for adolescent substance misuse: A systematic review. *Journal of Child & Adolescent Substance Abuse, 25*(3), 229-244. doi:10.1080/1067828X.2014.981772
- 8) Bergman, B. G., Hoepfner, B. B., Nelson, L. M., Slaymaker, V., & Kelly, J. F. (2015). The effects of continuing care on emerging adult outcomes following residential addiction treatment. *Drug and Alcohol Dependence, 153*, 207-214.
- 9) Bernstein, E., Bernstein, J., Tassiopoulos, K., Heeren, T., Levenson, S., & Hingson, R. (2005). Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence, 77*, 49-59.
- 10) Betty Ford Institute Consensus Panel. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment, 33*, 221-228. doi:10.1016/j.jsat.2007.06.001
- 11) Bobakova, D., Madarasova Geckova, A., Reijneveld, S. A., & van Dijk, J. P. (2012). Subculture affiliation is associated with substance use of adolescents. *European Addiction Research, 18*(2), 91-6.
- 12) Boisvert, R. A., Martin, L. M., Grosek, M., & Claire, A. J. (2008). Effectiveness of a peer-support community in addiction recovery: participation as intervention. *Occupational Therapy International, 15*(4), 205-220.
- 13) Braciszewski, J. M., & Stout, R. L. (2012). Substance use among current and former foster youth: A systematic review. *Children and Youth Services Review, 34*(12), 2337-2344.
- 14) Braciszewski, J. M., Stout, R. L., Tzilos, G. K., Moore, R. S., Bock, B. C., & Chamberlain, P. (2016). Testing a dynamic automated substance use intervention model for youths exiting foster care. *Journal of Child and Adolescent Substance Abuse, 25*(3), 181-187. doi: 10.1080/1067828X.2014.981771
- 15) Bradford, S., & Rickwood, D. (2015). Acceptability and utility of an electronic psychosocial assessment (MyAssessment) to increase self-disclosure in youth mental healthcare: A quasi-experimental study. *BioMed Central Psychiatry, 15*, 305. doi: 10.1186/s12888-015-0694-4
- 16) Buckley, L., Sheehan, M., & Chapman, R. (2009). Adolescent protective behavior to reduce drug and alcohol use, alcohol-related harm and interpersonal violence. *Journal of Drug Education, 39*(3), 289-301.
- 17) Burgstahler, S. (1997). Peer support: what role can the internet play? *Information Technology and Disabilities, 4*(4).
- 18) Butman, M. (2009). Peer mentoring: Real recovery for young adults. *Focal Point, 23*(2), 28-31.
- 19) Campbell, J., & Leaver, J. (2003). *Emerging new practices in organized peer support. Report from NTAC's National Experts Meeting on Emerging New Practices in Organized Peer Support*, March 17-18, 2003 Alexandria, VA. Prepared for the National Technical Assistance Center for State Mental Health Planning, National Association of State Mental Health Program Directors, under contract with the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
- 20) Cappelli, M., Davidson, S., Racek, J., Leon, S., Vloet, M., Tataryn, K., Gillis, K., Freeland, A., Carver, J., Thatte, S., & Lowe, J. (2014). Transitioning Youth into Adult Mental Health and Addiction Services: An Outcomes Evaluation of the Youth Transition Project. *The Journal of Behavioral Health Services & Research, 1-14*. doi:10.1007/s11414-014-9440-9
- 21) Casanueva, C., Stambaugh, L., Urato, M., Goldman Fraser, J., & Williams, J. (2011). Lost in transition: Illicit substance use and services receipt among at-risk youth in the child welfare system. *Children and Youth Services Review, 33*(10), 1939-1949.
- 22) Cavanaugh, D., Goldman, S., Friesen, B., & Lan Le, M. P. A. (2009). *Designing a Recovery-Oriented Care Model for Adolescents and Transition Age Youth with Substance Use or Co-Occurring Mental Health Disorders*. Rockville, MD: Substance Abuse and Mental Health Services Administration, USDHHS. Retrieved

- from [http://gucchdtacenter.georgetown.edu/resources/Recovery\\_Report\\_Adolescents](http://gucchdtacenter.georgetown.edu/resources/Recovery_Report_Adolescents), 20, 20.
- 23) Center for Substance Abuse Treatment (CSAT. 2006). *Emerging Peer Recovery Support Services and Indicators of Quality: An RCSP Conference Report*. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
  - 24) Center for Substance Abuse Treatment (CSAT, 2009). *What are Peer Recovery Support Services?* HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
  - 25) Chambers, M., Connor, S.L., & McElhinney, S. (2005). Substance use and young people: The potential of technology. *Journal of Psychiatric and Mental Health Nursing*, 12(2), 179-186.
  - 26) Champion, K. E., Newton, N. C., Barrett, E. L., & Teesson, M. (2013). A systematic review of school-based alcohol and other drug prevention programs facilitated by computers or the internet. *Drug and Alcohol Review*, 32(2), 115-123.
  - 27) Chung, T., & Maisto, S. A. (2006). Relapse to alcohol and other drug use in treated adolescents: Review and reconsideration of relapse as a change point in clinical course. *Clinical Psychology Review*, 26(2), 149-161.
  - 28) Chung, T., Sealy, L., Abraham, M., Ruglovsky, C., Schall, J., & Maisto, S. A. (2015). Personal network characteristics of youth in substance use treatment: Motivation for and perceived difficulty of positive network change. *Substance Abuse*, 36(3), 380-8.
  - 29) Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance Use & Misuse*, 43(12-13), 1971-1986.
  - 30) Collier, C., Hilliker, R., & Onwuegbuzie, A. (2014). Alternative peer group: A model for youth recovery. *Journal of Groups in Addiction & Recovery*, 9, 40-53. doi:10.1080/1556035X.2013.836899
  - 31) Collier, C., Simpson, S., Najera, J., & Weiner, L. (2012). Peer influence and recovery. *The Prevention Researcher*, 19(5), 6-8. Retrieved from <http://go.galegroup.com/ps/i.do?i=GALE%7CA325091247&v=2.1&u=txshracd2509&it=r&p=HRCA&sw=w&asid=1fd28fbdcc2781476876f7336ef1543>
  - 32) Cook, S. H., Bauermeister, J. A., Gordon-Messer, D., & Zimmerman, M. A. (2013). Online network influences on emerging adults' alcohol and drug use. *Journal of Youth and Adolescence*, 42(11), 1674-86.
  - 33) Czuchry, M., Sia, T. L., & Dansereau, D. F. (1999). Preventing alcohol abuse: an examination of the "Downward Spiral" game and educational videos. *Journal of Drug Education*, 29(4), 323-335.
  - 34) Daniels, A., Grant, E., Filson, B., Powell, I., Fricks, L., & Goodale, L. (Eds.). (2010). *The pillars of peer support: Transforming mental health systems of care through peer support services*, <http://www.pillarsofpeersupport.org/>.
  - 35) Dasinger, L. K., Shane, P. A., & Martinovich, Z. (2004). Assessing the effectiveness of community-based substance abuse treatment for adolescents. *Journal of Psychoactive Drugs*, 36(1), 27-33.
  - 36) Davidson, L., White, W., Sells, D., Schmutte, T., O'Connell, M., Bellamy, C., & Rowe, M. (2010). Enabling or engaging? The role of recovery support services in addiction recovery. *Alcoholism Treatment Quarterly*, 28(4), 391-416. doi:10.1080/07347324.2010.511057
  - 37) Dennis, M. L., Godley, S. H., Diamond, G. S., Tims, F. M., Babor, T., Donaldson, J., Liddle, J., Titus, J.C., Kaminer, Y., Webb, C., Hamilton, N., & Funk, R. R. (2004). *The Cannabis Youth Treatment (CYT) Study: Main findings from two randomized trials*. *Journal of Substance Abuse Treatment*, 27, 197-213. doi:10.1016/j.jsat.2003.09.005
  - 38) Dingle, G. A., Stark, C., Cruwys, T., & Best, D. (2015). Breaking good: breaking ties with social groups may be good for recovery from substance misuse. *British Journal of Social Psychology*, 54(2), 236-54
  - 39) Di Noia, J., Schwinn, T. M., Dastur, Z. A., & Schinke, S. P. (2003). The relative efficacy of pamphlets, CD-ROM, and the Internet for disseminating adolescent drug abuse prevention programs: An exploratory study. *Preventive Medicine*, 37(6 Pt. 1), 646-653.
  - 40) Dishion, T. J., McCord, J., & Poulin, F. (1999). When interventions harm: Peer groups and problem behavior. *American Psychologist*, 54(9), 755.
  - 41) Dugdale, S., Elison, S., Davies, G., Ward, J., & Dalton, M. (2016). Using the transtheoretical model to explore the impact of peer mentoring on peer mentors. *Journal of Groups in Addiction & Recovery*, 11(3), 166-181. DOI:10.1080/1556035X.2016.1177769
  - 42) Duncan, T. E., Duncan, S. C., Beauchamp, N., Wells, J., & Ary, D. V. (2000). Development and evaluation of an interactive CD-ROM refusal skills program to prevent youth substance use: "Refuse to use." *Journal of Behavioral Medicine*, 23(1), 59-72.
  - 43) Duncan, S. C., Gau, J. M., Duncan, T. E., & Strycker, L. A. (2011). Development and correlates of alcohol use from ages 13-20. *Journal of Drug Education*, 41(3), 235-52.
  - 44) Eisenberg, D., Golberstein, E., & Whitlock, J. L. (2014). Peer effects on risky behaviors: New evidence from college roommate assignments. *Journal of Health Economics*, 33, 126-38.
  - 45) Faces and Voices of Recovery (Ed.). (2010). *Addiction recovery peer service roles: Recovery management in health reform*. Washington, DC: Faces and Voices of Recovery.
  - 46) Feske, U., Tarter, R. E., Kirisci, L., Gao, Z., Reynolds, M., & Vanyukov, M. (2008). Peer environment mediates parental history and individual risk in the etiology of cannabis use disorder in boys: a 10-year prospective study. *American Journal of Drug and Alcohol Abuse*, 34(3), 307-20.
  - 47) Finch, A. J. (2003). *A sense of place at Recovery High School: Boundary permeability and student recovery support*. (Unpublished doctoral dissertation). Vanderbilt University, Nashville, TN.



- 48) Finch, A. J. (2004). First person: Portrait of a recovery high school. *Counselor*, 5(2), 30-32.
- 49) Finch, A. J. (2004). On campus, in recovery, but without support. *Behavioral Health Management*, 24(5), 37-41.
- 50) Finch, A. J. (2005). *Starting a recovery high school: A how-to manual*. Center City, MN: Hazelden Publishing.
- 51) Finch, A. J. (2007). Authentic voices: Stories from recovery school students. *Journal of Groups in Addiction and Recovery*, 2(2-4), 16-37.
- 52) Finch, A. J. (2007). Rationale for including recovery as part of the educational agenda. *Journal of Groups in Addiction and Recovery*, 2(2-4), 1-15.
- 53) Finch, A. J. (2012). The recovery school movement: History and outlook. In A.E. Skinstad, K. Summers, & P.E. Nathan (Eds.). *Proceedings of the 4th Annual Symposium, Recovery schools: A provider's introduction to recovery programs in high schools and post-secondary schools*. Iowa City, IA: Prairielands Addiction Technology Transfer Center.
- 54) Finch, A. J. (2015). Recovery high schools 101. *Counselor*, 16(2), 19-21.
- 55) Finch, A. J., & Frieden, G. (2014). The ecological and developmental role of recovery schools. *Peabody Journal of Education*, 89(2), 271-287.
- 56) Finch, A. J., & Karakos, H. (Eds.) (2014). Substance abuse recovery and schooling: The role of recovery high schools and collegiate recovery communities. A special edition of the *Peabody Journal of Education*.
- 57) Finch, A. J., & Moberg, D.P. (Eds.) (Scheduled 2014). Substance abuse recovery and schooling: The role of recovery high schools and collegiate recovery communities. *A special edition of the Peabody Journal of Education*.
- 58) Finch, A. J., Moberg, D.P., & Krupp, A.L. (2014). Continuing care in high schools: A descriptive study of recovery high school programs. *Journal of Child and Adolescent Substance Abuse*, 23(2), 116-129.
- 59) Finch, A. J., & Wegman, H. (2012). Recovery high schools: Opportunities for support and personal growth for students in recovery. *The Prevention Researcher*, 19 (supplement), pp. 12-16.
- 60) Fisher, L. B., Miles, I. W., Austin, S. B., Camargo, C. A., & Colditz, G. A. (2007). Predictors of initiation of alcohol use among US adolescents: Findings from a prospective cohort study. *Archives of Pediatric and Adolescent Medicine*, 161(10), 959-66.
- 62) Fleming, C. B., White, H. R., Oesterle, S., Haggerty, K. P., & Catalano, R. F. (2010). Romantic relationship status changes and substance use among 18- to 20-year-olds. *Journal of Studies on Alcohol and Drugs*, 71(6), 847-56.
- 63) Garner, B. R., Godley, M. D., Funk, R. R., Dennis, M. L., & Godley, S. H. (2007). The impact of recovery management adherence on environmental risks, substance use, and substance-related problems following adolescent residential treatment. *Psychology of Addictive Behaviors*, 21(4), 488-497.
- 64) Garner, B. R., Godley, M. D., Passetti, L. L., Funk, R. R., & White, W. L. (2014). Recovery support for adolescents with substance use disorders: The impact of recovery support telephone calls provided by pre-professional volunteers. *Journal of Substance Abuse and Alcoholism*. 2(2), 1010.
- 65) Gayman, M. D., Cuddeback, G. S., & Morrissey, J. P. (2011). Help-seeking behaviors in a community sample of young adults with substance use disorders. *The Journal of Behavioral Health Services & Research*, 38(4), 464-477.
- 66) Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R. R., & Passetti, L. L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, 23, 21-32.
- 67) Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R. R., & Passetti, L. L. (2006). The effect of assertive continuing care on continuing care linkage, adherence, and abstinence following residential treatment for adolescent substance use disorders. *Addiction*, 102, 81-93.
- 68) Godley S. H., Garner, B. R., Passetti, L. L., Funk, R. R., Dennis, M. L., & Godley, M. D. (2010). Adolescent outpatient treatment and continuing care: Main findings from a randomized clinical trial. *Drug and Alcohol Dependence*, 110(1-2), 44-54.
- 69) Godley, S. H., Passetti, L. L., & White, M. K. (2006). Employment and adolescent alcohol and drug treatment: An exploratory study. *American Journal on Addictions*, 15, 137-143.
- 70) Goldman, J. (1986, June 15). A place for teens to hold on to sobriety; Recovery home is foundation's goal. *Los Angeles Times*, Westside Home Edition, 4pp.
- 71) Gonzalez, V. M., & Dulin, P. L. (2015). Comparison of a smartphone app for alcohol use disorders with an internet-based intervention plus bibliotherapy: A pilot study. *Journal of Consulting and Clinical Psychology*, 3(2), 335-345.
- 72) Groß, C., Neumann, M., Kalkbrenner, M., Mick, I., Lachnit, A., Reichert, J., Klotsche, J., & Zimmermann, U. S. (2014). A retrospective analysis of psychosocial risk factors modulating adolescent alcohol binge drinking. *European Addiction Research*, 20(6), 285-92.
- 73) Gudonis-Miller, L. C., Lewis, L., Tong, Y., Tu, W., & Aalsma, M. C. (2012). Adolescent romantic couples influence on substance use in young adulthood. *Journal of Adolescence*, 35(3), 638-47.
- 74) Gulliver, A., Farrer, L., Chan, J. K., Tait, R.J., Bennett, K., Calear, A. L., & Griffiths, K. M. (2015). Technology-based interventions for tobacco and other drug use in university and college students: A systematic review and meta-analysis. *Addiction Science & Clinical Practice*, 10, 5. doi: 10.1186/s13722-015-0027-4
- 75) Haberle, B., Conway, S., Valentine, P., Evans, A. C., White, W. & Davidson, L. (2014). The recovery

- community center: A new model for volunteer peer support to promote recovery. *Journal of Groups in Addiction and Recovery*, 9, 237-256.
- 76) Harris, K. S., Baker, A. K., Kimball, T. G., & Shumway, S. T. (2008). Achieving systems-based sustained recovery: A comprehensive model for collegiate recovery communities. *Journal of Groups in Addiction & Recovery*, 2(2-4), 220-237.
- 77) Harris, S. K., & Knight, J. R. (2014). Putting the screen in screening: Technology-based alcohol screening and brief interventions in medical settings. *Alcohol Research*, 36(1), 63-79.
- 78) Havlicek, J. R., Garcia, A. R., & Smith, D. C. (2013). Mental health and substance use disorders among foster youth transitioning to adulthood: Past research and future directions. *Children and Youth Services Review*, 35(1), 194-203.
- 79) Heron, K. E., & Smyth, J. M. (2010). Ecological momentary interventions: Incorporating mobile technology into psychosocial and health behavior treatments. *British Journal of Health Psychology*, 15(Pt. 1), 1-39.
- 80) Heslin, K. C., Hamilton, A. B., Singzon, T. K., Smith, J. L., & Anderson, N. L. (2011). Alternative families in recovery: Fictive kin relationships among residents of sober living homes. *Qualitative Health Research*, 21(4), 477-488.
- 81) Heslin, K. C., Singzon, T., Aimiuwu, O., Sheridan, D., & Hamilton, A. (2012). From personal tragedy to personal challenge: Responses to stigma among sober living home residents and operators. *Sociology of Health & Illness*, 14(3), 379-395.
- 82) Hill, T., McDaid, C., & Taylor, P. (2012, February 21-23). *Peer recovery support services: Evolving community-based practices and infrastructure*. Paper presented at the Betty Ford Institute Conference on Recovery, Rancho Mirage, California.
- 83) Hong, T., Beaudoin, C. E., & Johnson, C. (2013). A panel study of peer norms and adolescent alcohol consumption: developing strategies for communication interventions. *Journal of Health Communication*, 18(8), 913-30.
- 84) Hu, X., Dodd, V. J., Oliverio, J. C., & Cook, R. L. (2014). Utilization of information and communication technology (ICT) among sexually transmitted disease clinics attendees with coexisting drinking problems. *BioMed Central Research Notes*, 7, 178. doi: 10.1186/1756-0500-7-178
- 85) Humphreys, K., & Lembke, A. (2013). Recovery-oriented policy and care systems in the UK and USA. *Drug and Alcohol Review*, DOI: 10.1111/dar.12092.
- 86) Humphreys, K., & McLellan, A. T. (2010). Brief intervention, treatment, and recovery support services for Americans who have substance use disorders: An overview of policy in the Obama administration. *Psychological Services*, 7(4), 275-284. doi: [10.1037/a0020390](https://doi.org/10.1037/a0020390)
- 87) Jackson, S. W. (2001). The wounded healer. *Bulletin of the History of Medicine*, 75, 1-36.
- 88) Jason, L.A., Mericle, A. A., Polcin, D. L., & White, W. L. (2013). The role of recovery residences in promoting long-term addiction recovery. *American Journal of Community Psychology*, 52, 406-411.
- 89) Jason, L. A., Olson, B. D., Ferrari, J. R., & Lo Sasso, A. T. (2006). Communal housing settings enhance substance abuse recovery. *American Journal of Public Health*, 96, 1727-1729. doi:10.2105/AJPH.2005.070839
- 90) Jason, L. A., Olson, B. D., Ferrari, J. R., Majer, J. M., Alvarez, J., & Stout, J. (2007). An examination of main and interactive effects of substance abuse recovery housing on multiple indicators of adjustment. *Addiction*, 102, 1114-1121. doi:10.1111/j.1360-0443.2007.01846.x
- 91) Joe, G. W., Knight, D. K., Becan, J. E., & Flynn, P. M. (2014). Recovery among adolescents: models for post-treatment gains in drug abuse treatments. *Journal of Substance Abuse Treatment*, 46(3), 362-73.
- 92) Kamon, J., & Turner, W. (2013). *Recovery coaching in recovery centers: What the initial data suggest: A brief report from the Vermont Recovery Network*. Montpelier, Vermont. (Retrieved from [https://vtrecoverynetwork.org/PDF/VRN\\_RC\\_eval\\_report.pdf](https://vtrecoverynetwork.org/PDF/VRN_RC_eval_report.pdf)).
- 93) Kaplan, K., Salzer, M. S., & Brusilovskiy, E. (2012). Community participation as a predictor of recovery-oriented outcomes among emerging and mature adults with mental illnesses. *Psychiatric Rehabilitation Journal*, 35(3), 219.
- 94) Kaplan, L. (2008). *The role of recovery support services in recovery-oriented systems of care*. DHHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Services, Substance Abuse and Mental Health Services Administration, 2008.
- 95) Kaplan, L., Nugent, C., Baker, M., & Clark, H. (2010). Introduction: The Recovery Community Services Program. *Alcoholism Treatment Quarterly*, 28(3), 244-255.
- 96) Kaufman, L., Brooks, W., Steinley-Bumgarner, M., & Stevens-Manser, S. (2012). *Peer specialist training and certification programs: A national overview*. Austin, TX: University of Texas at Austin Center for Social Work Research.
- 97) Kay-Lambkin, F. J., Baker, A. L., Geddes, J., Hunt, S. A., Woodcock, K. L., Teesson, M., Oldmeadow, C., Lewin, T.J., Bewick, B.M., Brady, K., Spring, B., Deady, M., Barrett, E., & Thornton, L. (2015). The iTreAD project: A study protocol for a randomised controlled clinical trial of online treatment and social networking for binge drinking and depression in young people. *BioMed Central Public Health*, 15, 1025. doi: 10.1186/s12889-01502365-2
- 98) Kelly, J. F., Brown, S. A., Abrantes, A., Kahler, C. W., & Myers, M. (2008). Social recovery model: An 8-year investigation of adolescent 12-Step group involvement following inpatient treatment. *Alcoholism: Clinical and Experimental Research*, 32(8), 1-11.

- 99) Kelly, J. F., Dow, S. J., Yeterian, J. D., & Kahler, C. W. (2010). Can 12-step group participation strengthen and extend the benefits of adolescent addiction treatment? A prospective analysis. *Drug and Alcohol Dependence*, 110(1-2), 117-125.
- 100) Kelly, J. F., Dow, S. J., Yeterian, J. D., & Myers, M. (2011). How safe are adolescents at AA and NA meetings? A prospective investigation with outpatient youth. *Journal of Substance Abuse Treatment*, 40(4), 419-428.
- 101) Kelly, J. F., & Myers, M. G. (2007). Adolescents' participation in Alcoholics Anonymous and Narcotics Anonymous: review, implications and future directions. *Journal of Psychoactive Drugs*, 39(3), 259-269.
- 102) Kelly, J. F., Myers, M. G., & Brown, S. A. (2000). A multivariate process model of adolescent 12-Step attendance and substance use outcome following inpatient treatment. *Psychology of Addictive Behaviors*, 14, 376-389.
- 103) Kelly, J. F., Myers, M. G., & Brown, S. A. (2002). Do adolescents affiliate with 12-Step groups? A multivariate process model of effects. *Journal of Studies on Alcohol*, 63, 293-304.
- 104) Kelly, J. F., Myers, M. G., & Brown, S. A. (2005). The effects of age composition of 12-Step groups on adolescent 12-Step participation and substance use outcome. *Journal of Child and Adolescent Substance Abuse*, 15, 63-72.
- 105) Kelly, J. F., Myers, M. G., & Rodolico, J. (2008). What do adolescents exposed to Alcoholics Anonymous think about 12-Step groups? *Substance Abuse*, 29(2), 53-72.
- 106) Kelly J. F., Pagano, M. E., Stout, R. L., & Johnson, S. M. (2011). The influence of religiosity on 12-step engagement and substance use disorder treatment response among adolescents. *Journal of Studies on Alcohol and Drugs*, 72(6), 1000-1011.
- 107) Kelly, J. F., Stout, R. L., Greene, M. C., & Slaymaker, V. (2014). Young adults, social networks, and addiction recovery: Post treatment changes in social ties and their role as a mediator of 12-step participation. *PLoS ONE*, 9(6), e100121.
- 108) Kelly, J. F., Stout, R. L., & Slaymaker, V. (2013). Emerging adults' treatment outcomes in relation to 12-step mutual-help attendance and active involvement. *Drug and Alcohol Dependence*, 129(1-20), 151-7.
- 109) Kelly, J. F., & Urbanoski, K. (2012). Youth recovery contexts: The incremental effects of 12-step attendance and involvement on adolescent outpatient outcomes. *Alcoholism: Clinical and Experimental Research*, 36(7), 1219-29.
- 110) Kelly, J., & White, W. (Eds.). (2011) *Addiction recovery management: Theory, science and practice*. New York: Springer Science.
- 111) Kendler, K. S., Ohlsson, H., Mezuk, B., Sundquist, K., & Sundquist, J. (2015). Exposure to peer deviance during childhood and risk for drug abuse: a Swedish national co-relative control study. *Psychological Medicine*, 45(4), 855-64.
- 112) Kim, B. K., Gloppen, K. M., Rhew, I. C., Oesterle, S., & Hawkins, J. D. (2015). Effects of the communities that care prevention system on youth reports of protective factors. *Prevention Science*, 16(5), 652-62.
- 113) Kingston, S., Knight, E., Williams, J., & Gordon, H. (2015). How do young adults view 12-Step programs? A qualitative study. *Journal of Addictive Diseases*, 34(4), 311-22.
- 114) Kwan, P. P., Sussman, S., & Valente, T. W. (2015). Peer leaders and substance use among high-risk adolescents. *Substance Use & Misuse*, 50(3), 283-91.
- 115) Laudet, A. B., & Humphreys, K. (2013). Promoting recovery in an evolving policy context: What do we know and what do we need to know about recovery support services? *Journal of Substance Abuse Treatment*, 45(1), 126-133.
- 116) Laudet, A. B., & White, W. L. (2008). Recovery capital as prospective predictor of sustained recovery, life satisfaction and stress among former poly-substance users. *Substance Use and Misuse*, 43(1), 27-54. doi:10.1080/10826080701681473
- 117) Lee, M. T., Pagano, M. E., Johnson, B. R., & Post, S. G. (2016). Love and service in adolescent addiction recovery. *Alcoholism Treatment Quarterly*, 34(2), 197-222.
- 118) Litt, M., Kadden, R., Kabela-Cormier, E., & Petry, N. (2007). Changing network support for drinking: Initial findings from the Network Support Project. *Journal of Consulting and Clinical Psychology*, 75(4), 542-555.
- 119) Litt, M., Kadden, R., Kabela-Cormier, E., & Petry, N. (2009). Changing network support for drinking: Network Support Project two-year follow-up. *Journal of Consulting and Clinical Psychology*, 77(2), 229-242.
- 120) Litwack, T., & White, W. (2014). Addiction recovery support: Contrasting and transcending professional and peer models. *Journal of Groups in Addiction and Recovery*, 9(3), 257-270.
- 121) Loveland, D., & Boyle, M. (2005). *Manual for recovery coaching and personal recovery plan development*. Posted at <http://www.bhrm.org/guidelines/addguidelines.htm>
- 122) Luthar, S. S., Anton, S. F., Merikangas, K. R., & Rounsaville, B. J. (1992). Vulnerability to drug abuse among opioid addicts' siblings: Individual, familial, and peer influences. *Comprehensive Psychiatry*, 33(3), 190-196.
- 123) Manteuffel, B., Stephens, R. L., Sondheimer, D. L., & Fisher, S. K. (2008). Characteristics, service experiences, and outcomes of transition-aged youth in systems of care: Programmatic and policy implications. *The Journal of Behavioral Health Services & Research*, 35(4), 469-487.
- 124) Margolis, R., Kilpatrick, A., & Mooney, B. (2000). A retrospective look at long-term adolescent recovery: Clinicians talk to researchers. *Journal of Psychoactive Drugs*, 32(1), 117-125.
- 125) Marsch, L. A., Bickel, W. K., & Grabinski, M. J. (2007). Application of interactive, computer technology to

- adolescent substance abuse prevention and treatment. *Adolescent Medicine: State of the Art Reviews*, 18(2), 342-356, xii.
- 126) Marsch, L. A., Grabinski, M. J., Bickel, W. K., Desrosiers, A., Guarino, H., Muehlbach, B., Solkhah, R., Taufique, S., & Acosta, M. (2011). Computer-assisted HIV prevention for youth with substance use disorders. *Substance Use & Misuse*, 46(1), 46-56.
  - 127) Marsch, L. A., Guarino, H., Grabinski, M. J., Syckes, C., Dillingham, E. T., Xie, H., & Crosier, B. S. (2015). Comparative effectiveness of web-based vs. educator-delivered HIV prevention for adolescent substance users: A randomized, controlled trial. *Journal of Substance Abuse Treatment*, 59, 30-37. doi:10.1016/j.jsat.2015.07.003
  - 128) Marschall-Lévesque, S., Castellanos-Ryan, N., Vitaro, F., & Séguin, J. R. (2014). Moderators of the association between peer and target adolescent substance use. *Addictive Behaviors*, 39(1), 48-70.
  - 129) Mead, S., & MacNeil, C. (2006). Peer support: What makes it unique? *International Journal of Psychosocial Rehabilitation*, 10(2), 29-37.
  - 130) Min, S. Y., Whitecraft, E., Rothbard, A. B., & Salzer, M. S. (2007). Peer support for persons with co-occurring disorders and community tenure: A survival analysis. *Psychiatric Rehabilitation Journal*, 30(3), 207-213.
  - 131) Minehart, M., White, W., Cantwell, A., Combs, M. P., Glazer, H., Korczykowski, J., Skipworth, K., Stewart-Smith, P., Uffner, E., & Vernig, P. M. (2014). *The integration of peer recovery supports within Philadelphia's Crisis Response Centers: An in-progress report from the field*. Posted at [www.williamwhitepapers.com](http://www.williamwhitepapers.com).
  - 132) Montanaro, E., Fiellin, L. E., Fakhouri, T., Kyriakides, T. C., & Duncan, L. R. (2015). Using videogame apps to assess gains in adolescents' substance use knowledge: New opportunities for evaluating intervention exposure and content mastery. *Journal of Medical Internet Research*, 17(10), e245. doi: 10.2196/jmir.4377
  - 133) Morrison, C., & Bailey, C. (2011). The alternative peer group: A recovery model for teens and young adults. *Recovery Today Online*.
  - 134) Naar-King, S., Outlaw, A., Green-Jones, M., Wright, K., & Parsons, J. T. (2009). Motivational interviewing by peer outreach workers: a pilot randomized clinical trial to retain adolescents and young adults in HIV care. *AIDS Care*, 21(7), 868-873.
  - 135) Nash, A. J. (2013). *The alternative peer group: What can 'winners' from this program teach us about recovery from adolescent substance use disorder?* (Unpublished doctoral dissertation). The University of Texas Health Science Center at Houston School of Nursing, Houston, TX.
  - 136) Nash, A., & Collier, C. (2016). The alternative peer group: Developmentally appropriate recovery support model for adolescents. *Journal of Addictions Nursing*, 27(2), 109-119.
  - 137) Nash, N., Marcus, M., Engebretson, J., & Bukstein, O. (2015). Recovery from adolescent substance use disorder: Young people in recovery describe the process and keys to success in an alternative peer group. *Journal of Groups in Addiction & Recovery*, 10(4), 290-312.
  - 138) Neiderhiser, J. M., Marceau, K., & Reiss, D. (2013). Four factors for the initiation of substance use by young adulthood: a 10-year follow-up twin and sibling study of marital conflict, monitoring, siblings, and peers. *Development and Psychopathology*, 25(1), 133-49.
  - 139) Ohannessian, C. M. (2009). Does technology use moderate the relationship between parental alcoholism and adolescent alcohol and cigarette use? *Addictive Behaviors*, 34(6-7), 606-609.
  - 140) Pagano, M. E., Post, S. G., & Johnson, S. M. (2011). Alcoholics Anonymous-related helping and the helper therapy principle. *Alcoholism Treatment Quarterly*, 29(1), 23-34.
  - 141) Pagano, M. E., Wang, A. R., Rowles, B. M., Lee, M. T., & Johnson, B. R. (2015). Social anxiety and peer helping in adolescent addiction treatment. *Alcoholism: Clinical and Experimental Research*, 39, 887-895.
  - 142) Pagano, M.E., Zeltner, B., Jaber, J., Post, S., Zywiak, W. H., & Stout, R. L. (2009). Helping others and long-term sobriety: Who should I help to stay sober? *Alcoholism Treatment Quarterly*, 27(1), 38-50.
  - 143) Pantridge, C., Charles, V.A., DeHart, D., & Browne, L.T. (2016). A qualitative study of the role of peer support specialists in substance use disorder treatment: Examining the types of support provided. *Alcoholism Treatment Quarterly*, 34(3), 337-353.
  - 144) Passetti, L., Godley, M., & Kaminer, Y. (2016). Continuing care for adolescents in treatment for substance use disorders. *Child & Adolescent Psychiatric Clinics*, 25(3). doi: <http://dx.doi.org/10.1016/j.chc.2016.06.003>
  - 145) Passetti, L. L., & Godley, S. H. (2008). Adolescent substance abuse treatment clinicians' self-help meeting referral practices and adolescent attendance rates. *Journal of Psychoactive Drugs*, 40, 29-40.
  - 146) Passetti, L., & White, W. (2008). Recovery meetings for youths. *Journal of Groups in Addiction and Recovery*, 2, 97-121. Published simultaneously as: Passetti, L.L. & White, W.L. (2008). Recovery support meetings for youths: Considerations when referring young people to 12-Step and alternative groups. In J.D. Roth & A.J. Finch (Eds.), *Approaches to substance abuse and addiction in education communities: A guide to practices that support recovery in adolescents and young adults*. NY: Haworth Press.
  - 147) Polcin, D. L., Korcha, R., & Bond, J. (2015). Interaction of motivation and psychiatric symptoms on substance abuse outcomes in sober living houses. *Substance Use and Misuse*, 50(2), 195-204.
  - 148) Polcin, D.L., Korcha, R., Bond, J., & Galloway, G.P. (2010). What did we learn from our study on sober living houses and where do we go from here? *Journal of Psychoactive Drugs*, 42, 425-433.
  - 149) Reboussin, B. A., Song, E. Y., & Wolfson, M. (2012). Social influences on the clustering of underage risky

- drinking and its consequences in communities. *Journal of Studies on Alcohol and Drugs*, 73(6), 890-8.
- 150) Reif, S., Braude, L., Lyman, D. R., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Salim, O., & Delphin-Rittman, M. E. (2014). Peer recovery support for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services*, 65, 853-861.
- 151) Repper, J., & Carter, T., (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, 20(4), 392-411.
- 152) Rice, E., Lee, A., & Taitt, S. (2011). Cell phone use among homeless youth: potential for new health interventions and research. *Journal of Urban Health*, 88(6), 1175-82.
- 153) Ridenour, T. A., Meyer-Chilenski, S., & Reid, E. E. (2012). Developmental momentum toward substance dependence: natural histories and pliability of risk factors in youth experiencing chronic stress. *Drug and Alcohol Dependence*, 123 Suppl 1, S87-98.
- 154) Riessman, F. (1965). The "helper" therapy principle. *Social Work*, April, 27-32.
- 155) Riestenberg, N. (2007). The restorative recovery school: Countering chemical dependency. *Reclaiming Children and Youth*, 16(2), 21-23.
- 156) Riper, H., van Straten, A., Keuken, M., Smit, F., Schippers, G., & Cuijpers, P. (2009). Curbing problem drinking with personalized-feedback interventions: A meta-analysis. *American Journal of Preventive Medicine*, 36(3), 247-255.
- 157) Rowe, M., Bellamy, C., Baranoski, M., Wieland, M., O'Connell, M. J., Benedict, P., & Sells, D. (2007). A peer-support, group intervention to reduce substance use and criminality among persons with severe mental illness. *Psychiatric Services*, 58(7), 955-961.
- 158) Schwartz, R.P., Gryczynski, J., Mitchell, S. G., Gonzales, A., Moseley A., Peterson, T. R., Ondersma, S. J., & O'Grady, K. E. (2014). Computerized versus in-person brief intervention for drug misuse: A randomized clinical trial. *Addiction*, 109(7), 1091-1098. doi: 10.1111/add.12502
- 159) Shandley, K., Austin, D., Klein, B., & Kyrios, M. (2010). An evaluation of 'Reach Out Central': An online gaming program supporting the mental health of young people. *Health Education Research*, 25(4), 563-574.
- 160) Sheedy, C., Whitter, M., & Chin, B. (2013). *SAMHSA national leadership summit on youth recovery meeting report*. (No. HHSS280201100002C). Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS).
- 161) Sheidow, A. J., McCart, M., Zajac, K., & Davis, M. (2012). Prevalence and impact of substance use among emerging adults with serious mental health conditions. *Psychiatric Rehabilitation Journal*, 35(3), 235.
- 162) Shook, J. J., Vaughn, M. G., Litschge, C., Kolivoski, K., & Schelbe, L. (2009). The importance of friends among foster youth aging out of care: Cluster profiles of deviant peer affiliations. *Children and Youth Services Review*, 31(2), 284-291.
- 163) Skorka-Brown, J., Andrade, J., Whalley, B., & May J. (2015). Playing Tetris decreases drug and other cravings in real world settings. *Addictive Behaviors*, 51, 165-170. doi: 10.1016/j.addbeh.2015.07.020
- 164) Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal*, 27(4), 392-401.
- 165) Spear, S. F., & Skala, S. Y. (1995). Posttreatment services for chemically dependent adolescents. *NIDA research monograph*, 156, 341-363.
- 166) Sussman, S. (2010). A review of Alcoholics Anonymous/ Narcotics Anonymous programs for teens. *Evaluation & the Health Professions*, 33(1), 26-55.
- 167) Teunissen, H. A., Spijkerman, R., Cohen, G. L., Prinstein, M. J., Engels, R. C., & Scholte, R. H. (2014). An experimental study on the effects of peer drinking norms on adolescents' drinker prototypes. *Addictive Behaviors*, 39(1), 85-93.
- 168) Thombs, D. L., Olds, R. S., Osborn, C. J., Cassetday, S., Glavin, K., & Berkowitz, A. D. (2007). Outcomes of a technology-based social norms intervention to deter alcohol use in freshman residence halls. *Journal of American College Health*, 55(6), 325-332.
- 169) Tracy, K., Burton, M., Nich, C., & Rounsaville, B. (2011). Utilizing peer mentorship to engage high recidivism substance-abusing patients in treatment. *American Journal of Drug and Alcohol Abuse*, 37, 525-531.
- 170) Trudeau, K. J., Ainscough, J., & Charity, S. (2012). Technology in treatment: Are adolescents and counselors interested in online relapse prevention? *Child Youth Care Forum*, 41(1), 57-71.
- 171) Tucker, J. S., Green, H. D., Zhou, A. J., Miles, J. N., Shih, R. A., & D'Amico, E. J. (2011). Substance use among middle school students: associations with self-rated and peer-nominated popularity. *Journal of Adolescence*, 34(3), 513-9.
- 172) Ullman, A. D., & Orenstein, A. (1994). Why some children of alcoholics become alcoholics: Emulation of the drinker. *Adolescence*, 29(113), 1-11. 67
- 173) Valente, T. W., Ritt-Olson, A., Stacy, A., Unger, J. B., Okamoto, J., & Sussman, S. (2007). Peer acceleration: effects of a social network tailored substance abuse prevention program among high-risk adolescents. *Addiction*, 102(11), 1804-1815.
- 174) Valentine, P. (2011). Peer-based recovery support services within a recovery community organization: The CCAR experience. In Kelly, J., & White, W. L. (Eds.), *Addiction recovery management: Theory, science and practice*. pp. 259-280. New York: Springer Science.
- 175) VanDeMark, N. R., Burrell, N. R., Lamendola, W. F. Hoich, C. A., Berg, N. P., & Medina, E. (2010). An

- exploratory study of engagement in a technology-supported substance abuse intervention. *Substance Abuse Treatment, Prevention, and Policy*, 5, 10. doi: 10.1186/1747-597X-5-10.
- 176) van Melick, M., McCartney, D., & Best, D. (2013). Ongoing recovery support and peer networks: A preliminary investigation of recovery champions and their peers. *Journal of Groups in Addiction and Recovery*, 8(3), 185-199.
- 177) Van Ryzin, M. J., & Dishion, T.J. (2014). Adolescent deviant peer clustering as an amplifying mechanism underlying the progression from early substance use to late adolescent dependence. *Journal of Child Psychology and Psychiatry*, 55(10), 1153-61.
- 178) Verkooijen, K. T., de Vries, N. K., & Nielsen, G. A. (2007). Youth crowds and substance use: the impact of perceived group norm and multiple group identification. *Psychology of Addictive Behaviors*, 21(1), 55-61.
- 179) Vervaeke, H. K., van Deursen, L., & Korf, D. J. (2008). The role of peers in the initiation and continuation of ecstasy use. *Substance Use and Misuse*, 43(5), 633-46.
- 180) Veysey, B.N., Grasmere, J., & Andersen, R. (2010). Supporting peer recovery in rural New England: The RECOVER Project, Franklin County, MA. *Alcoholism Treatment Quarterly*, 28(3), 306-325.
- 181) Vogl, L. E., Newton, N. C., Champion, K. E., & Teesson, M. (2014). A universal harm-minimisation approach to preventing psychostimulant and cannabis use in adolescents: A cluster randomised controlled trial. *Substance Abuse Treatment, Prevention, and Policy*, 9, 24. doi: 10.1186/1747-597X-9-24
- 182) White, W. (1979). *Relapse as a phenomenon of staff burnout in recovering substance abusers*. Rockville, MD: HCS, Inc.
- 183) White, W. (2005). Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly*, 23(1), 3-15.
- 184) White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, 33, 229-241. doi:10.1016/j.jsat.2007.04.015
- 185) White, W. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.
- 186) White, W. (2008). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse*, 43, (12&13), 1987-2000.
- 187) White, W. L. (2009). *Peer-based addiction recovery support: History, theory, practice, and scientific evaluation*. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.
- 188) White, W. (2010). Non-clinical addiction recovery support services: History, rationale, models, potentials and pitfalls. *Alcoholism Treatment Quarterly*, 28, 256-272.
- 189) White, W. L. (2012). *Recovery/Remission from Substance Use Disorders: An Analysis of Reported Outcomes in 415 Scientific Studies, 1868-2011*. Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Intellectual Disability Services Mental Retardation Services and Northeast Addiction Technology Transfer Center.
- 190) White, W., Dennis, M., & Godley, M. (2002). Adolescent substance use disorders: From acute treatment to recovery management. *Reclaiming Children and Youth*, 11(3), 172-175.
- 191) White, W. L. & Evans, A. C. (2014). The recovery agenda: The shared role of peers and professionals. *Public Health Reviews*, 35(2), 1-15.
- 192) White, W. L., Evans, A. C., Ali, S., Achara-Abrahams, I., & King, J. (2009). *The recovery revolution: Will it include children, adolescents, and transition age youth?* Philadelphia, PA: Department of Behavioral Health and Mental Retardation Services.
- 193) White, W., & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor*, 7(2), 54-57.
- 194) White, W., & Godley, S. (2007). Adolescent recovery: What we need to know. *Student Assistance Journal*, 19(2), 20-25.
- 195) White, W., Humphreys, K., Bourgeois, M., Chiapella, P., Evans, A., Flaherty, M., Gaumont, P., Haggerson, P., Haberle, B., Hill, T., Kaskutas, L.A., Kelly, J., McDaid, C., Powell, J., Scott, C., & Taylor, P., (2013) *The status and future of addiction recovery support services in the United States: Report of the BFI/UCLA Consensus Conference on Recovery Support Services*, February 2012.
- 196) White, W., Kelly, J., & Roth, J. (2012). New addiction recovery support institutions:
- 197) Mobilizing support beyond professional addiction treatment and recovery mutual aid. *Journal of Groups in Addiction & Recovery*, 7(2-3), 297-313.
- 198) White, W. L., the PRO-ACT Ethics Workgroup, with legal discussion by Popovits, R. & Donohue, B. (2007). *Ethical guidelines for the delivery of peer-based recovery support services*. Philadelphia: Philadelphia Department of Behavioral Health and Mental Retardation Services.
- 199) Whitter, M., Hillman, D. J., & Powers, P. (2013). Recovery-Oriented Systems of Care (ROSC) Resource Guide. *Journal of Drug Addiction, Education, and Eradication*, 9(4), 361.
- 200) Wiebel, W. W., Biernacki, P. Mulia, N. & Levin, L. (1993). Outreach to IDUs not in treatment. In B. Brown and G. Meschner (Eds.), *Handbook on Risk of AIDS: Injection drug users and sexual partners*. Westport, CT: Greenwood Press.
- 201) Williams, R. J., & Chang, S. Y. (2000). A comprehensive and comparative review of adolescent substance abuse treatment outcomes. *Clinical Psychology: Science and Practice*, 7, 138-166.

202) Windle, M. (2000). Parental, sibling, and peer influences on adolescent substance use and alcohol problems. *Applied Developmental Science, 4*, 98-110.

203) Witkiewitz, K., Desai, S. A., Bowen, S., Leigh, B. C., Kirouac, M., & Larimer, M. E. (2014). Development and evaluation of a mobile intervention for heavy drinking and smoking among college students. *Psychology of Addictive Behaviors, 28*(3), 639-650. doi: 10.1037/a0034747

204) Wodarski, J. S., Macmaster, S., & Miller, N. K. (2012). The use of computer technology to reduce and prevent college drinking. *Social Work in Public Health, 27*(3), 270-282.

205) Yao, P., Ciesla, J. R., Mazurek, K. D., & Spear, S. F. (2012). Peer relations scale for adolescents treated for substance use disorder: a factor analytic presentation. *Substance Abuse Treatment, Prevention, and Policy, 7*, 29.

206) Zemore, S. E. (2007). Helping as healing among recovering alcoholics. *Southern Medical Journal, 100*(4), 447-450.

207) Zemore, S. E., Kaskutas, L. A., & Ammon, L. N. (2004). In 12-step groups, helping helps the helper. *Addiction, 99*(8), 1015-1023.

3. De Miranda, J., Williams, G. (2011). Youth in Recovery, April 2011, Volume 18(2), The Prevention Researcher
4. Judy Nelson, Susan Henderson, and Steve Lackey, (2014). Presentation: Alternative Peer Groups: Adolescent Recovery From Substance Use, Sam Houston State University TCA Conference
5. Martin, Jordan, Razavi, Burnham, Linfoot, Knudson, DeVet, Hudson, & Dumas (2017). Substance Use Disorder Peer Supervision Competencies, The Regional Facilitation Center, Portland, Oregon.
6. Stacie Mathewson Foundation, Transforming Youth Recovery. Activity and Program Toolkit.
7. Stacie Mathewson Foundation, Transforming Youth Recovery. Marketing and Outreach Toolkit.
8. Stacie Mathewson Foundation, Transforming Youth Recovery. Collegiate Recovery Program Staff Job Description Toolkit.
9. Stacie Mathewson Foundation, Transforming Youth Recovery (2015). 2015 Collegiate Recovery Asset Survey Report
10. Stacie Mathewson Foundation, Transforming Youth Recovery. The Assets for Building Collegiate Recovery Capacity.
11. Turpin, A. & Shier, M. (2017). Peer support and substance use disorder treatment: Benefits and barriers for intrapersonal development in longer-term treatment programs. *Journal of Groups in Addiction & Recovery, 12*(2-3), 117-134.

# Appendix 1

## Validation Survey of Substance Use Disorder Transition Age Youth Peer Best Practices

*Eric Martin*, MAC, CADC III, PRC, CPS,

*Tony Vezina*, A.A.S., PRC

**Methodology:** A 5-scale Likert Validation Survey ranging from “very important for TAY SUD Peers to demonstrate or perform” to “not important for TAY SUD Peers to perform this task,” was statistically ranked by TAY experienced SUD Peer Mentors. Mean, median, variance, confidence intervals, margins of error, and standard deviations were evaluated to refer unreliable “best practice statements” to the DACUM workgroup for re-evaluation and editing. Participants responded to best practice statements through a Turning Point Response system.



# Likert Validation Survey

Best Practice Description	Mean	Median	Variance	S.D.	C.I.
<b>Best Practice One: SUD Peer Services Created, Directed, and Delivered by Youth.</b> SUD youth peer services are best, designed, operationalized and administered by youth. Youth-centric services include: policies regarding age of individuals served; youth-centric hours of operation for peer services, drop-in hours and events; youth-oriented outreach, geographical accessibility, including access to public transportation; youth-oriented policies & procedures; and greater opportunities for consumer involvement within the agency. A 2015 survey of 145 College Recovery Programs (CRP's) nationwide found, to start a college recovery program the highest ranked asset is existing students in recovery who are motivated to develop the program.	1.00	1.00	0.00	0.00	(95%) 1 ± 0
<b>Best Practice Two: Facilitate Branding.</b> Branding is an important element of youth peer delivered services. Branding requires input from peer staff and consumers and involves; values important to young people in recovery; such as socialization, non-traditional care, and non-traditional designs incorporating social media. The Mathewson Foundation TYR Toolkits highlight the imperative of "branding" for collegiate youth peer programs.	1.40	1.00	0.24	0.49	(95%) 1.4 ± 0.43
<b>Best Practice Three: Dedicated Safe Physical Space.</b> Youth require a dedicated space designed for safety vs. "appropriateness" or administrative convenience. A dedicated functional space demonstrates a commitment to youth recovery. Historically, many collegiate recovery programs have been relegated to small rooms little more than closets, simply for administrative convenience. The collegiate recovery literature often relates feelings of undervaluation and stigma that are experienced by SUD youth staff, volunteers, and participants when they aren't afforded adequate space.	1.00	1.00	0.00	0.00	(95%) 1 ± 0
<b>Best Practice Four: Building Youth Social &amp; Recovery Communities.</b> SUD youth peer services have a greater focus on affiliation and socialization vs. individual and emotional support. Research regarding youth substance use and abstinence, reveals that both are correlated to broader peer groups and social influences. Youth peer services assist consumers with integration into the larger youth recovery community creating a sense of "community" or "family." Building a youth recovery community requires empowerment through shared responsibilities and leadership development.	1.00	1.00	0.00	0.00	(95%) 1 ± 0
<b>Best Practice Five: Facilitating Event/Activity-Based Recovery.</b> SUD youth peer services are activity-based. Youth peer recovery groups have a long history of prosocial events and recreational activities dating back to the 1940's. In the 1940's, Alcoholics Anonymous groups for persons 35 and under formed in metropolitan areas around the U.S. In 1952, Riverside Hospital began the first treatment center dedicated to adolescents and included recreational activities as a part of their programming. In 1958, the International Conference of Young People in Alcoholics Anonymous (ICYPAA) is founded, producing area and national conferences typically hosting: dances, parties, comedy shows, open mics, etc. Several research studies on adolescent treatment and Alternative Peer Groups (APG's) highlight the importance of prosocial and recreational activities as a part of youth recovery programs.	1.20	1.00	0.16	0.40	(95%) 1.2 ± 0.35
<b>Best Practice Six: Effective use of Technology.</b> SUD youth peer services rely heavily on technology, including, but not limited to: texting, email, Facebook, Twitter, Snapchat, Instagram, homepages, meeting and resource directories, ACHES, Sobergrid, Squirrel, online surveys, etc. Youth peer programs are cognizant of HIPAA compliant telecommunications, limitations, consent required for Facebook communications and other similar public forums. Youth are presented with informed consent regarding electronic communications, and a risk and benefit description, before agreeing to participate in	1.00	1.00	0.00	0.00	(95%) 1 ± 0

communications that are not HIPAA compliant. Surveying youth through technology is an important feature of “ownership” in youth peer services. Electronic surveys of youth participants give everyone a voice in the direction of services, events, aesthetics/branding, policies, purchases (games, food), etc. (See Appendix: Electronic Communication Informed Consent)					
<b>Best Practice Seven: Screening Youth.</b> Screening youth for appropriateness of services is an important aspect of SUD youth peer programs. For example, 18-20 year old’s have the highest rate of substance use and many experience emotionally-driven episodic substance-related problems that would not necessarily meet the diagnostic criteria for a severe substance use disorder (addiction). Youth peer programs are dedicated to addiction recovery and must be able to screen participants to maintain their primary mission and purpose of striving towards abstinence. Many allied behavioral health professionals have a difficult time understanding the distinction between episodic emotionally driven substance use, and chronic addiction largely driven by tolerance and withdrawal.	1.20	1.00	0.16	0.40	(95%) 1.2 ± 0.35
<b>Best Practice Eight: Embrace Diversity, Inclusivity &amp; Individuality within the Primary Mission.</b> SUD youth peer services have diverse participants with a wide variation in recovery capital compared to traditional behavioral health care organizations. Traditional behavioral health care agencies tend to be more stratified by specialty services and funding with more economically homogenized clients (for example: residential treatment for low-income women with children involved in child welfare, or specialty treatment for affluent and employed licensed professionals with private insurance). SUD youth peer services have participants ranging from stable teens and young adults with supportive affluent families to homeless teens and young adults with little to no resources or family support. Moreover, youth peer programs embrace cultural/ethnic diversity, LGBTQ2I individuals, unconventional youth, those with mental health challenges, and those with varying disabilities. Programs develop policies and practices to ensure equality, equity, and safety for all participants. The challenges of inclusivity are overcome through an unrelenting focus on the primary mission of SUD recovery.	1.00	1.00	0.00	0.00	(95%) 1 ± 0
<b>Best Practice Nine: Person-centered and Trauma-informed Care.</b> Youth peer programs are youth-centric employing “youthful persons in recovery” who are trained and prepared to offer person-centered and directed services. Many youth with addiction have already experienced involuntary commitment to addiction treatment or mental health services, including forced medication, juvenile detention/probation, or other highly directive services. Subsequently, many youth are unaccustomed to person-centered and self-directed care. Staff offer their knowledge and experience, reviewing pros and cons of various life decisions, while eliciting self-directed goals from youth participants. Staff are trained to offer trauma-informed services to traditionally marginalized, oppressed, and stigmatized populations (cultural/ethnic minorities, LGBTQ2I youth, those with addiction & mental health challenges, those with varying disabilities).	1.20	1.00	0.16	0.40	(95%) 1.2 ± 0.35
<b>Best Practice Ten: Intensive Contact Post-treatment.</b> Contemporary treatment research reveals that youth are at greatest risk of relapse within 30 days post-treatment, and that post-treatment activities significantly reduce a return to substance use. Youth peers strive to meet individuals at their treatment agencies prior to discharge (warm hand off) and engage in assertive outreach with individuals post-treatment.	1.00	1.00	0.00	0.00	(95%) 1 ± 0
<b>Best Practice Eleven: Supporting self-management of high-risk social groups.</b> Research reveals that youth are more heavily influenced by their social relationships and peer groups, compared to middle-aged and older adults. Relapses, including return to chronic substance use and related problems are often associated with peer influences. Youth peers assist and support individuals in enhancing their own recovery environment and avoiding high-risk peer groups, risky hangouts and self-management of challenging family circumstances.	1.40	1.00	0.24	0.49	(95%) 1.4 ± 0.43

<b>Best Practice Twelve: Employment &amp; Education.</b> Youth peer staff support young recovering individuals in developing a plan for living that includes education and employment with growth potential. Research regarding youth employment post-treatment is confounding. While most treatment-related research suggests that employment is a major factor in recovery post-treatment, some research indicates that among youth, full-time employment post-treatment is associated with higher rates of relapse. There are a variety of reasons why this might be true. Youth leaving addiction treatment who immediately begin working full-time might be less invested in developing a recovery support program and network and now have a significant amount of disposable income from their full-time employment. Additionally, many jobs offered to youth may also carry a risk of relapse associated with the substance use within low wage industries that do not have drugfree workplace policies. Youth peer mentors assist individuals in assessing the pros of cons of education and training vs. immediately entering the workforce.	1.40	1.00	0.24	0.49	(95%) 1.4 ± 0.43
<b>Best Practice Thirteen: System Navigation: Supporting the Inexperienced.</b> Youth peers understand that most young people do not always know or understand complex bureaucratic systems (banking, criminal justice, child welfare, health care/Medicaid, colleges, vocational training, TANF, SNAP, housing agencies, addiction treatment, mental health, etc.). Youth peers educate and assist in orienting individuals to the culture, rules, and opportunities within varied systems.	1.20	1.00	0.16	0.40	(95%) 1.2 ± 0.35
<b>Best Practice Fourteen: Boundaries &amp; Role Ambiguity Inherent in TAY Peer Services.</b> Youth peers understand their professional ethical and legal obligations. Youth peers acknowledge that boundaries between peers and individuals receiving services must be managed for the safety of the individual, program and environment. Youth peers who share the same recovery social networks do not compromise confidentiality, the integrity of services or competing interests.	1.20	1.00	0.16	0.40	(95%) 1.2 ± 0.35
<b>Best Practice Fifteen: Maturing Recovery, Health &amp; Wellness.</b> Physical and mental health are inextricably linked and improving one can help to improve the other. Peer staff understand the importance of wellness and support individuals in developing healthy habits that incorporate the SAMSHA Eight Dimensions of Wellness.	1.20	1.00	0.16	0.40	(95%) 1.2 ± 0.35

Our Likert survey reveals that best practice statements (#2, #11, #12) present the lowest consensus/reliability with a variance of 0.24, standard deviation 0.49, and 95% confidence interval of 1.4 ± 0.43. These three Best Practice statements were referred back to the SME workgroup for further clarification and editing.

## Appendix 2

# Sample Social Media/Electronic Communication: Informed Consent & Release for youth peer programs

**Introduction:** This release of information and statement of informed consent aims to address two primary concerns regarding confidentiality.

- 1) Unencrypted communications between peer staff and program program participants (e.g. unencrypted telephonic texting, unencrypted email, and unencrypted “private” messaging through social networking applications).
- 2) Photos and Videos taken at recovery events (dances, parties, karaoke night, sporting activities, comedy night, etc.) that may be posted to social networking sites.

## 4<sup>th</sup> Dimension Recovery Center Social Media/Electronic Communication: Informed Consent & Release

4th Dimension Recovery Center, 3801 NE MLK Jr Blvd, Portland, Oregon 97211

Peer Service Participant Name:

DOB or Social Security:

Date:

*This is to authorize the release of information regarding the above client.*

**Applicable Regulations:** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Code of Federal Regulation 42 part 2, Privacy Rules, or Standards for Privacy of Individually Identifiable Health Information, establishes national standards for the protection of certain health information, including identifying information regarding those who participate in alcohol and drug services. The Security Standards for the Protection of Electronic Protected Health Information (the Security Rule) establish a national set of security standards for protecting certain health information that is held or transferred in electronic form. The Security Rule operationalizes the protections contained in the Privacy Rule by addressing the technical and non-technical safeguards that organizations called “covered entities” must put in place to secure individuals’ “electronic protected health information” (e-PHI). This form is provided by 4<sup>th</sup> Dimension Recovery Center for general convenience purposes and does not represent legal advice. If you feel you need legal consultation in addition to what we’ve provided, be sure to consult your attorney including seeking advice pertaining to HIPAA compliance, 42 CFR part 2, the HITECH Act, and the U.S. Department of Health and Human Services regulations. 4<sup>th</sup> Dimension Recovery Center is a peer support organization supporting the youth recovery community of Multnomah County. We are NOT attorneys, and although this form is based on our own research to ensure compliance, it does not represent legal advice.

**Parties to the release:** This release is between 4th Dimension Recovery Center (youth peer staff and volunteers) and Social Media Entities (Instagram, Facebook, Twitter, 4th Dimension Website, Sobergrid, and individuals who may review 4<sup>th</sup> Dimension outcome data) and between any individuals who may be viewing unencrypted email or unencrypted telephonic text messaging.

**Purpose of release:** The photographic/video images, and/or testimonials (postings) of clients will be used for: Social Media supporting the recovery community at large. I understand that if I am attending events at the 4th Dimension Recovery Center, that those images may be posted to the 4th Dimension website or other newsfeeds. The purpose of post-event photographic postings is to further build, inspire and market recovery from alcohol & drug addiction. The primary function of unencrypted electronic communication (email/texting) is primarily for logistical purposes setting appointments/meetings/transportation, etc.

**Release:**

1. The 4<sup>th</sup> Dimension Recovery Center is authorized to use, disclose, discuss information about me, and with me through unencrypted text/email at my request. The 4<sup>th</sup> Dimension Recovery Center may also post images of me participating in a variety of recovery related events on multiple social networking platforms. Additionally, I understand that other event participants who are not employed at 4<sup>th</sup> Dimension may be taking photos and posting them to social networking sites.
2. The specific information that may be disclosed is:
  - a. Photographic images of me from community recovery events at 4<sup>th</sup> Dimension Recovery Center posted to Facebook, Twitter, Instagram, etc.
  - b. 4D may accept your social media comments/posts and respond to comments/posts that you may post to the 4<sup>th</sup> Dimension Recovery Facebook page, Twitter, Instagram, Sobergrid etc.
  - c. Testimonials/comments that you may submit to 4<sup>th</sup> Dimension Recovery Center website and/or reports.
  - d. Unsecured electronic communications via email or texting regarding appointments or other activities. Unsecured private communications through Facebook, Sobergrid, etc.
  - e. Responses to your unencrypted emails/text that may include unencrypted discussions regarding personal protected information. 4<sup>th</sup> Dimension staff will not initiate unencrypted communications regarding your personal health information, but may respond to comments or discussions that you initiate through unencrypted email/texting.
3. I understand that I should consider limiting personal self-disclosures through electronic media: 4<sup>th</sup> Dimension Recovery Center's Facebook, Twitter, Instagram accounts and unencrypted email and phone texting. 4<sup>th</sup> Dimension staff encourage all participants to use unencrypted electronic communication (email/texting) for the primary purposes of logistical meetings and appointments and should refrain from lengthy disclosures through these forms of media.
4. I understand I can revoke this permission at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. I understand that the 4th Dimension Recovery Center cannot condition services on whether or not I sign this authorization.
6. I understand, that by signing any or all of this release may result in the disclosure of my recovery status and enrollment in alcohol and drug services.
7. If desired, copy provided:  
 "Yes, I would like a copy of this form."

## Please initial all elements of communications that you agree to

4D Unencrypted Email Communications					
Initial	Communicate with you through unencrypted email regarding 4D services, appointments, and other logistical request.	Initial	Communicate with you through unencrypted email discussing issues related to your participating in services.	Initial	Communicate with you through unencrypted email discussing your recovery status, including milestones.
4D Unencrypted Telephonic Texting Communications					
Initial	Communicate with you through unencrypted telephonic text messages regarding 4D services, appointments, and other logistical request.	Initial	Communicate with you through unencrypted telephonic text discussing issues related to your participating in services.	Initial	Communicate with you through unencrypted telephonic text discussing your recovery status, including milestones.
Facebook:					
Initial	Post recovery event pictures to facebook which may include you	Initial	Accept and respond to your Post & Post-responses regarding participation in 4D Peer Services to Facebook	Initial	Accept and respond to your Post & Post-responses regarding your recovery status to Facebook, including milestones
Instagram:					
Initial	Post recovery event pictures to Instagram which may include you	Initial	Accept and respond to your Post & Post-responses regarding participation in 4D Peer Services to Instagram	Initial	Accept and respond to your Post & Post-responses regarding your recovery status to Instagram, including milestones
Twitter:					
Initial	Post pictures to Twitter which may include you	Initial	Accept and respond to your Post & Post-responses regarding participation in 4D Peer Services to Twitter	Initial	Accept and respond to your Post & Post-responses regarding your recovery status to Twitter, including milestones
Sobergrid:					
Initial	Respond to communications from you in Sobergrid	Initial	Accept and respond to your Post & Post-responses regarding participation in 4D Peer Services to Sobergrid	Initial	Accept and respond to your Post & Post-responses regarding your recovery status to Sobergrid, including milestones
4D Website:					
Initial	Post recovery event pictures to 4D website which may include you	Initial	Accept your testimonials regarding participation in 4D Peer Services to 4D website	Initial	Accept your testimonials regarding your recovery status to 4D website, including milestones
4D Informative Reports (success outcome reports, etc)					
Initial	Post recovery event pictures to informative reports which may include you	Initial	Accept your testimonials regarding participation in 4D Peer Services to reports	Initial	Accept your testimonials regarding your recovery status to reports, including milestones

**EXPIRATION OF CONSENT DATE:** \_\_\_\_\_, or Condition/Event: 180 days after last peer participant contact.

I understand I can revoke this permission at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I have been informed of the risks and benefits associated with unencrypted communications and sharing/discussing my personal information on social networks. I have been encouraged to limit my private communications with 4D peer staff to logistical concerns (appointment times, transportation times/issues, etc.) and to be cognizant of photographs/video taken at recovery events.

**SIGNATURES CERTIFYING APPROVAL FOR TWO-WAY RELEASE OF INFORMATION:**

---

Signature of Peer Program Participant Date

---

Signature of Parent/Guardian Date

---

Signature of Witness or Agent Authorized for Releasing Information Date