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Recovery Supports for Young People: What Do Existing Supports Reveal About the Recovery Environment?

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Abstract

This article seeks to address how our understanding of the recovery process and resulting supports can be made more comprehensive: how can links from treatment to home to school to communities be made so that there are fewer and fewer recovery gaps for adolescents? Using the ecology of recovery model developed by White (2009) as the impetus for such a review, the article discusses the challenges inherent within adolescent substance abuse recovery, factors impacting successful recovery, and programs addressing this issue that have been empirically studied. Studied programs can be categorized as (1) formalized aftercare recovery and (2) recovery communities, and both examples will be described using existing literature. From the review of existing recovery support research and resources, the discussion highlights gaps and future research areas in order to address the complexity of recovery among young people.

In 2011, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that for the previous year, 75.9% of youths reported receiving substance use prevention messages, and 11.5% of youths reported participating in substance use prevention programs outside of school (SAMHSA, 2011a). Even with such a targeted focus on substance use prevention among adolescents in the United States, adolescents are still engaging in substance use, which subsequently results in substance dependence or abuse. Based on a compilation of reports from all U.S. facilities reporting treatment admissions to their State administration, the proportion of adolescent treatment admissions has remained relatively stable from 2000–2010 (SAMHSA, 2011b). However, this means that during each year approximately 7% of all state-reported substance abuse treatment admissions were for 12–17 year olds. This leads to the question: what happens to this vulnerable population when they are released to the community after inpatient treatment or when outpatient treatment ends due to processes in the treatment system or adolescents' lives?

Unfortunately, research illustrates that there is a general trend of high rates of substance relapse and subsequent treatment readmission among adolescents. One study found that 61.1% of adolescents who completed a 28-day inpatient treatment program relapsed to pretreatment usage levels within 12 months of treatment (Spear, Ciesla, & Skala, 1999). Cornelius and colleagues (2003) found that 66% of adolescents who completed outpatient treatment relapsed within the first six months following their treatment. Given the high rate

of substance relapse among those who reenter “drug-saturated social environments,” White has argued that without community efforts to reshape the environment, the repeated inpatient readmission of youth for treatment “... is a form of institutional profiteering, in effect if not in intent” (White, 2009, pp. 151). To avoid engaging in the exploitation that White warns against, it is first necessary to understand the available forms of post treatment recovery programs in adolescents’ communities. Therefore, in order to better understand how the recovery process is actualized for young people, this article will first briefly describe the adolescent treatment and recovery process and then review adolescent recovery in the community context. Finally, using findings from the systematic literature review, the discussion will describe existing recovery support resources, gaps, and future research areas in order to address the complexity of recovery among young people.

Treatment and the Recovery Process

Historically, adult recovery models were somewhat unsuccessfully applied to adolescent substance use disorder (SUD) treatment and recovery (Deas, Riggs, Langenbucher, Goldman, & Brown, 2000). Indeed, prior to 1990, published research literature specifically focused on adolescent treatment and recovery was rare (Sussman, 2010). Now, however, among practitioners and researchers, adolescents are viewed not as “miniature adults,” but as individuals who require developmentally appropriate approaches for substance abuse treatment and recovery support (Ciesla, Valle, & Spear, 2008; Deas et al., 2000; Spear & Skala, 1995).

Treatment for adolescent substance abuse is often initiated by formal enrollment into an outpatient or inpatient treatment program. There are over 11,000 licensed or certified substance abuse treatment programs in the U.S., some of which are designated specifically for adolescents (SAMHSA, 2012). In general, inpatient adolescent treatment programs typically last between one and three months (Godley, Godley, Dennis, Funk, & Passetti, 2002), although the exact amount of time spent in treatment may change depending on recommendations made by program staff. Once treatment has ended, either abruptly or through its natural course, youth then return to their home environment, often where their initial substance problems began. This can be especially challenging for adolescents who were enrolled in inpatient treatment, because these programs have not given them opportunities to practice their sobriety in their home environment (Cavailoa, Schiff, & Kane-Cavailoa, 1990), or prepared them for the competing demands in their unstructured, community environments (Gonzales et al., 2012).

Researchers have studied various factors that impact the possibility of relapse, and while this appears to vary among youth, certain components appear to be more relevant to substance abuse recovery than others. These factors include initial substance addiction severity (Anderson, Ramo, Schulte, Cummins, & Brown, 2007); individual motivation and skills for abstinence (Chung & Maisto, 2006); co-occurring mental illness (Chung & Maisto, 2006; Deas et al., 2000); a safe and supportive family environment (Richter, Brown, & Mott, 1991); and having peers that are supportive of one’s recovery (Kelly & Myers, 2007; Richter et al., 1991). Thus, as would be expected, there are many factors at individual,

interindividual, and community levels that interact to create healthy (or unhealthy) recovery environments.

Acknowledging the many factors that contribute to substance dependence and abuse, practitioners and researchers recognized that substance abuse is more appropriately and successfully treated as a chronic disease that requires lifelong attention and targeted supports (McKay, 2001; White, 2009; White, 2012). The present use of a chronic disease management lens for substance abuse recovery illustrates a positive shift insofar as practitioners now view the recovery process along a continuum, and therefore attempt to provide sustained support to adolescents who need it, making them less likely to relapse. Yet, applying the chronic disease lens for substance abuse recovery highlights gaps in our understanding of this process. The recommended length and intensity of recovery services varies (Cavailoa, Schiff, & Kane-Cavailoa, 1990), and, although some have suggested delineating between early, sustained, and stable sobriety, there has been no established consensus across or within disciplines on this time frame for any population (The Betty Ford Institute Consensus Panel, 2007). While there is general agreement among researchers and practitioners in the United States on what program factors constitute the formal treatment process for adolescents, recovery is still a debated concept both in practice and in theory (Spear, Ciesla, & Skala, 1999; Spear & Skala, 1995; The Betty Ford Institute Consensus Panel, 2007). Recovery, for the purposes of this paper, is discussed as the time after an adolescent has received some initial form of formal treatment, and that initial treatment could be either inpatient or outpatient.

Ecology of Addiction Recovery

The various interacting factors that are evident once youth have left a supportive treatment environment have led authors to suggest that the difficult work of recovery *begins* when the adolescent returns to his or her pre-treatment environment (Godley et al., 1994; Godley, Kahn, Dennis, Godley, & Funk, 2005; Gonzales et al., 2012; White, 2009). A theory on the “ecology of addiction recovery” has thus been proposed to address the fact that individuals are treated and they then often return to the environment that helped to foster their substance use (White, 2009, pp. 147). Similar to other theories that recognize the different levels of impact on an individual’s behavior in a specific context (Sallis, Owen, & Fisher, 2008), the ecology of addiction recovery uses an ecological framework. This framework is used as a tool with which to view the individual within the surrounding physical, social, and cultural environment in order to better understand how his/her relationship with these contexts can directly affect substance abuse and recovery (White, 2009). Essentially, the framework recognizes that recovery occurs in stages and substance use problems and recovery occur both at the individual level and between individuals and their families and communities. Additionally, because there is often physical, psychological, and cultural distance between the treatment environment and community environment, recovery can only happen for individuals when they are in their community and outside the treatment environment. Thus, in order to change harmful family or community environments, White recognized the need to build and maintain a recovery community, inclusive of recovery supports, at the interindividual (meso) level.

Review of Recovery Supports

The above principles illustrate the importance of understanding the various individual and environmental factors that lead to and sustain recovery (Bronfenbrenner, 1977; White, 2009), as well as what supports have been implemented, specifically with young people in mind, that build individual resilience and/or buffer environmental risks leading to relapse. In order to understand the various supports already in place, as well as the gaps in supports for adolescents, a systematic review of the research literature was undertaken in 2012 by this article's author¹.

Method

The literature search involved reviewing multiple databases: PsychInfo, Social Services Abstracts, and PubMed. Grey (i.e., unpublished) literature was searched for using the following sources: a subsection of the Substance Abuse and Mental Health Services Administration (SAMHSA) website, the National Registry of Effective Programs and Practices (<http://nrepp.samhsa.gov>); Project CORK Database of Substance Abuse Information (http://www.projectcork.org/database_search/); and an expert in the field for adolescent treatment and recovery provided articles and access to an electronic reference database, which was searched by hand. Articles were included if they met the following criteria: it was a research-based article located in one of the databases outlined above or located in the bibliography of any article found through the aforementioned search (snowball sampling); and it focused on adolescents, substance abuse, recovery (also known as aftercare or continuing care), program evaluation, or evaluation of factors determining post treatment program success (a complete list of search terms is available upon request). Nineteen articles were ultimately eligible for inclusion in the review.

Results

Using the results of the systematic literature review, adolescent recovery programs can be categorized into two broad categories: formalized aftercare services and recovery communities.

Formal Aftercare Services

The term “aftercare services” refers to those services that are typically based out of the public health or substance abuse treatment system. There have been some attempts to create and evaluate the effectiveness of these formalized aftercare programs for adolescents who have successfully completed treatment. Based on this published research, studied aftercare services appear to be linked to specific treatment centers. While the two examples in this article may not accurately represent all available formalized support options for adolescents, they appear to be representative of the typical programs that have been formally evaluated and reported. The two examples are assertive continuing care (Garner, Godley, Funk,

¹Although this paper includes Collegiate Recovery Communities, these programs were not found in the systematic literature review as that review was focused on adolescent recovery processes instead of young adults or adults. As a result, the information in this paper regarding Collegiate Recovery Communities (page 12) was discovered through conversations with experts in the field and after a brief review of existing electronic literature databases for relevant collegiate recovery literature.

Dennis, & Godley, 2007; Godley, Godley, Dennis, Funk, & Passetti, 2002; 2007) and active aftercare (Burlison, Kaminer, & Burke, 2012; Kaminer, Burlison, & Burke, 2008). Both interventions have sought to ensure engagement of adolescents in some form of formalized aftercare support because previous research illustrated that the level of adolescent participation in any type of aftercare program is low and wanes over time in spite of clinical referral (Godley, Godley, & Dennis, 2001; Kelly, Myers, & Brown, 2000; Kelly & Urbanoski, 2012). These two interventions were designed with the goal of increasing youth aftercare attendance as researchers hypothesized that increased aftercare adherence would lead to reduced relapse rates among youth.

Godley and colleagues (2002; 2007) described a study where they compared usual continuing care (UCC) with a more intense, assertive continuing care (ACC) program. In the UCC condition, at inpatient treatment discharge, providers referred adolescents to outpatient providers in their home communities. Adolescents in the ACC condition were also referred to continuing care services, but in addition, were assigned a case-manager for 90 days. The case manager traveled to adolescents' homes weekly and met with them and their caregivers. The ACC program aimed to facilitate adolescents and their caregivers' engagement in prosocial activities, skill building, and utilization of existing community services through weekly home visits by a case manager. Nine months after treatment, youth with the more active involvement from the case manager (i.e., those in the ACC group) had both significantly higher rates of aftercare program adherence and decreased substance use compared to youth in the UCC group (Godley et al., 2007). Thus, it appears that the more active form of support by the case manager enabled adolescents to continue attending aftercare programming which in turn helped them to remain abstinent or, if using substances, use them less and less often.

Kaminer and colleagues (2008, 2012) described a study where they compared three conditions: non-active aftercare (no intervention by practitioner), brief telephone intervention with a practitioner, and in-person intervention with a practitioner. Youth who had completed treatment were randomized to one of the three conditions. Both of the active aftercare conditions (brief telephone and in-person) lasted for five sessions. While the content for the telephone and in-person sessions were the same, the duration that the adolescent met with the practitioner was longer in the in-person condition (50 minutes versus 12–15 minutes on the telephone). In this study, the likelihood of relapse increased over time for youth in all conditions, but youth in both active aftercare conditions had significantly lower levels of relapse and reported significantly fewer drinking and heavy drinking days than did those in the non-active aftercare condition (Kaminer et al., 2008).

These research examples illustrate the clinical importance of actively pursuing recovering adolescents following formal treatment. The brief telephone intervention (Kaminer et al., 2008, 2012) expanded aftercare options by highlighting the potential for less-expensive forms of clinical follow-up that are not constrained to a particular geographic area. Although both studies are helpful in gaining an understanding of how adolescents are supported after treatment, these examples are also highly individualized and appear to only be available to adolescents and their families who choose specific treatment facilities. Additionally, it is important to note that the home-based visits in the ACC program (Godley et al., 2002; 2007;

Garner et al., 2007) could address potential home environment issues, yet the community space outside the adolescent's home is not addressed in this approach. Program enrollment is also based on the potential for self-selection among privileged and highly supportive families, so it is unclear if this approach would benefit youth who are in greater need of home-based change.

Recovery Communities

Recovery communities have typically taken two forms: (1) academic recovery institutions or institutional-based support and (2) community-based self-help groups for the general population of individuals in recovery. Academic recovery institutions and institutional-based supports are discussed extensively throughout this special issue (i.e., see Moberg & Finch, 2014; Harris, Kimball, Casiraghi, & Arbenowske, 2014); this section will briefly address them, but the main focus will be on discussing alternative recovery community supports for young people, such as self-help groups.

Recovery High Schools—Recovery high schools (RHS) are one type of academic recovery institution that has been developed specifically for adolescents who are in recovery from substance dependence and abuse (Moberg & Finch, 2007). The goal of RHSs is to offer youth a safe learning environment that simultaneously fosters substance abuse recovery and academic advancement. Essentially, RHSs seek to create a space where youth can feel as equals among peers and understood by school staff and students alike. For example, one RHS website states their entrance criteria as follows: “Students interested in attending a recovery high school... must establish their willingness to work towards completion of district academic requirements... [They] must also be willing to... abstain from drugs and alcohol and participat[e] in an outside plan of recovery” (William J. Ostiguy High School, n.d.).

Although individual schools typically share some of the same underlying principles, such as a vision for sobriety, they differ in many organizational aspects based on their location, staff, founders, and participants. Schools generally have a small student body but can range in size from 5 to 80 students. Class sizes range throughout the year, sometimes as much as daily (Moberg & Finch, 2007), and students are occasionally given the choice of whether they want to graduate from the RHS or return to their former high school for graduation (Oser, personal communication, January 3, 2013). RHSs are most typically embedded within a larger school system with careful attention to ensuring separation of students from the traditional school (Moberg & Finch, 2007), but some can also be found in less traditional locations, including basements, church buildings, and former hotels (Finch, personal communication, May 21, 2013). Over the past 30 years, approximately 70 of these schools have been opened, the first one in Maryland in 1979 (Ruben, June 22, 2000). As of June, 2013, the directory of recovery schools from the Association of Recovery Schools (ARS, n.d.) listed 29 schools located across the United States: schools are located in California, Indiana, Massachusetts, Minnesota, New Hampshire, New York, Ohio, Rhode Island, Texas, Wisconsin, and Wyoming.

There is a limited amount of research data on the effectiveness of RHS; however, available evidence does suggest these schools might be effective in reducing relapse to substance use and are simultaneously successful in helping their students succeed academically (Kochanek, 2008; Lanham, 2011; Moberg & Finch, 2007; Moberg & Thaler, 1995). Additionally, because national survey research has illustrated that students in the United States are exposed to and have even received substances in the traditional school setting (Centers for Disease Control and Prevention, 2012), RHSs, with their insistence on substance-free learning spaces and procedures to find and address any relapse to substance use, fill an important gap. The RHS model thus supports the recommendations made by White (2009) in that they create an alternative academic recovery space at the interindividual level for adolescents. It is also important to note, however, that while fulfilling a necessary need, an adolescent's actual access to an RHS may produce recovery disparities: attendance at the school depends on many factors, such as knowledge about this support, geographic proximity to the school, and access to transportation.

Collegiate Recovery Communities—There are fewer Collegiate Recovery Communities (CRCs) than recovery high schools, yet these are also spread across the United States (Harris, Kimball, Casiraghi, & Arbenowske, this issue). The collegiate community list retrieved from the ARS in June, 2013 included 18 collegiate communities located in the following states: Connecticut, Georgia, Michigan, Minnesota, New Jersey, North Carolina, Ohio, Oklahoma, South Dakota, Tennessee, Texas, Vermont, and Virginia. One of the largest CRCs that has been in place for the longest, the CRC at Texas Tech University, has around 60 members: other CRCs have ranged in size from five to 80 members (Cleveland, Harris, Baker, Herbert, & Dean, 2007). Similar to RHSs, CRCs exist in an academic arena and seek to provide college students in recovery with appropriate recovery supports and a social environment that encourages abstinence. CRCs differ from RHSs, however, in that they do not typically offer separate academic classes for students in recovery, but they do sometimes offer scholarships towards university fees, and in some cases, substance-free, supervised housing (dormitories) are available. There is limited research evidence on the impact that CRCs have on college students in recovery, but this field is growing: a 13-site study is currently underway to better explore the impacts of CRCs on recovering college students (The Center For The Study Of Addiction & Recovery, n.d.).

Twelve-Step Programs—Across the United States, the most widely known and studied recovery communities are known as the 12-Step, self-help groups. Twelve-Step programs, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), were originally intended for and studied among adults. Although adolescents attend 12-Step programs, they are often in the minority. As of 2011, approximately 2% of those surveyed who reported attending 12-Step programs across America were under 21 years of age (Alcoholics Anonymous, 2012). Yet, as early as 1990, 12-Step programs were recommended as places to facilitate youth recovery after treatment (Sussman, 2010). Twelve-Step programs are free for anyone to attend, offer meetings on various days of the week and at various locations, and are a “fellowship of men and women who share their experience, strength and hope with each other” in order to help each other through the recovery process and achieve sobriety (Alcoholics Anonymous, 2012, p. 1). Depending on the local community, 12-Step meetings

can be composed of a few or a hundred members and are held in diverse spaces, such as churches, community centers, or hospitals; recent data from AA indicates that in the United States alone there are over 57,000 AA groups (Alcoholics Anonymous, n.d.). Meetings tend to open with announcements, are followed by members voluntarily speaking anonymously in front of the group, after which there is a voluntary donation time, and finally conclude with an informal social gathering where coffee and snacks are served.

In addition to 12-Step programs taking place as a freestanding meeting, 12-Step program elements are often incorporated into adolescent treatment programs and attending 12-Step meetings in the community has been built into some outpatient treatment programs. While there does exist a form of 12-Step program for recovering youth, called Teen Addiction Anonymous (Teen Addiction Anonymous, 2013), research studies on adolescent attendance at 12-Step programs have generally focused on the context of the community-based 12-Step programs, such as AA or NA.

Twelve-Step Attendance Research and Previous Reviews—Two recent literature reviews describe 12-Step attendance among those who attend either AA or NA and relationship to relapse among adolescents (Kelly & Myers, 2007; Sussman, 2010). Both reviews highlight what research suggests is a potential positive relationship for youth who attend AA/NA and recovery from substance abuse. In addition, a recent meta-analysis of the relationship between adolescent 12-Step attendance after formal treatment and relapse, found a positive significant main effect for adolescents who attended 12-Step programs (Fisher & Fisher, n.d.). The significant correlation illustrated that those who attended 12-Step three times a week gained an additional week of abstinence when compared to those only attending once a week. This additional week of abstinence is valuable when considering research findings that show that the longer one remains abstinent, the less likely one is to relapse (Higgins, Badger, & Budney, 2000).

It has been argued, however, that 12-Step programs as originally intended for adults are not appropriate for adolescents or are not as beneficial to them as other recovery supports may be. Researchers have suggested a need for monitoring adolescents' attendance and involvement in 12-Step programs and to teach them appropriate meeting etiquette (Cavailoa, Schiff, & Kane-Cavailoa, 1990; Passetti & White, 2010). To better understand the mechanisms by which 12-Step program attendance could be effective, in addition to studying the direct relationship between 12-step attendance and substance use outcomes, researchers have begun to study mediating factors among youth who attend 12-Step programs. To understand this relationship on an individual level, researchers have studied coping, self-efficacy, and motivation for abstinence (Kelly, Myers, & Brown, 2000). Other studies have looked at individual self-reported engagement with 12-Step programs such as affiliation with or active involvement in 12-Step programs (Chi, Campbell, Sterling, & Weisner, 2011; Kelly, Myers, & Brown, 2002; Margolis, Kilpatrick, & Mooney, 2000). Research has also addressed the nature of 12-Step programs, including the age composition of meetings (Kelly, Myers, & Brown, 2005) and self-reported feelings of safety (Kelly, Dow, Yeterian, & Myers, 2011). These studies indicate that adolescents generally do feel safe at meetings and that 12-Step attendance or non-attendance is not highly related to feelings of safety at the meetings. It also seems that the age composition of meetings does

influence attendance and subsequent relapse such that adolescents who attend 12-step groups composed of more similarly aged peers tend to be more engaged in 12-Step and also have decreased levels of substance use.

Additionally, there is a limited amount of research on the potential impact of spirituality or 12-Step's focus on spirituality on attendance and 12-Step program affiliation. In one qualitative study of young adults who had been sober for two to sixteen years, researchers found spirituality was a vital component of a majority of their respondents' recovery processes (Margolis et al., 2000); yet, others have suggested the spiritual focus in 12-Step may be problematic for adolescents who do not consider themselves religious (Kelly & Myers, 2007). One recent study included a measure of spirituality by asking about religious service attendance. Although results illustrated that religious service attendance might partially explain the relationship between 12-Step affiliation and drug use, the authors cautioned against making a strong case for the influence of religiosity on substance use from these results. Religiosity was measured simply as religious service attendance in the past six months, so this finding could be simply a sign of an adolescent re-engaging with their local community and is not a robust or reliable measure of spirituality (Chi et al., 2011).

Overall, it appears that some youth do attend 12-Step programs in the community after treatment and that attendance at 12-Step meetings is one factor contributing to continued abstinence among young people; however, it is still unclear whether there is a stronger impact for those of certain ethnicities or genders and whether the relationship is stronger in rural versus suburban or urban areas. In addition, measuring 12-Step attendance also introduces a self-selection bias: some adolescents may not be able to attend meetings due to lack of transportation or lack of parental support for program attendance. So, while 12-Step programs offer youth an abstinence-based social support at an inter-individual level in their communities, it is difficult to liken this kind of social network with the kind that is often the most influential for young people, i.e., peers that are close in age (Romer & Hennessy, 2007). It may instead be considered a type of supportive community, but one that is very different from the kind of environment that RHSs and CRCs offer.

Conclusions and Implications

As a result of the numbers of youth experiencing substance abuse and subsequent relapse after treatment, researchers have investigated many potentially important youth recovery factors and supports, including those that address individual behaviors and those that attempt to change community-level supports. These studies have all illustrated the importance of the post treatment environment among adolescents in recovery. They have also pointed to viable recovery support options for youth; yet, how widely available these resources are and how well these options address the needs of a diverse set of youth is still not completely understood. It appears that for some young people, utilizing a formal aftercare support service is feasible and effective. For others, attending 12-Step programs is just as effective and is a sustainable, cost-effective option. For still others, however, the recovery school environment may be the best alternative. Recovery school environments do appear to have an added benefit for youth as they enable adolescents to be surrounded by others, who are working towards sobriety and education, whereas adolescents utilizing aftercare or 12-Step

programs may be experiencing multiple levels of risk for relapse outside of the meeting experience, including in the traditional school setting.

Within all these research questions and findings, there is still a need for research to address how individual characteristics mediate the relationship between recovery programs and outcomes (Fisher et al., 2002). For example, it is unclear how to support certain subpopulations and more vulnerable populations of youth, including minorities. Indeed, as noted in a recent review of 12-Step programs for adolescents, Caucasian youth are highly represented in treatment and post treatment studies (Sussman, 2010), which limits conclusions we can make about recovery among other ethnicities. Additionally, our understanding of the recovery process between genders is still not clear, as studies have produced mixed results on outcomes for females versus males (Chung & Maisto, 2006). From results of the systematic review reported here, it also appears that males have traditionally been proportionally overrepresented in post treatment study samples, with studies typically reporting a 60–70% male sample. When considering these individual-level factors, the importance of understanding how duration, dose, and type of follow-up impact different youth is highlighted. Does a telephone follow-up work better for rural versus urban youth? Would electronic communication be just as (in)effective? Do hypothesized barriers, such as transportation, cause inconsistent aftercare attendance? If so, what are the characteristics of those experiencing the greatest lack of access? How does religiosity impact recovery, and what are alternative motivational sources for non-spiritual youth?

It is important to note the limits of the existing literature in order to improve future recovery research and conclusions we can draw from it. Although evaluation studies of specific aftercare programs have typically randomized participants, other studies of adolescents in recovery (i.e. those attending 12-Step programs) have been observational. Thus, we cannot make causal inferences regarding particular aftercare programs and SUD outcomes. Additionally, youth who enroll and remain in these studies are likely different than those who do not, and they perhaps have a different level of resources than those who are lost to attrition (Meyers, Webb, Frantz, & Randall, 2003). Thus, the other factors that are outside of their program attendance, but still impact attendance, must be studied in order to fully understand the process of adolescent recovery.

From an ecological framework, because the adolescent recovery process is embedded in the community, which is “the soil in which... the resolutions to such problems thrive or fail to thrive over time” (White, 2009, pp. 151), it seems essential to address what environmental support is necessary for sustained recovery. Indeed, developing a deeper understanding of what programs will work best for whom and which adolescents have access to what programs appears to be the next step to take for researchers in the field of adolescent recovery.

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Biography

Emily Fisher is currently a PhD student at Vanderbilt University's Peabody College. She has an undergraduate degree in Psychology from Gordon College and a Master of Philosophy degree in Health Promotion from the University of Bergen, during which she completed a U.S.-Norway Fulbright fellowship. Her research focus is on adolescent development, with a focus on how school settings foster healthy physical and psychosocial development.