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Support Services for Young Adults With Substance Use Disorders

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Abstract

In summarizing the proceedings of longitudinal meeting of experts in substance use disorder (SUD) among young adults, this special article reviews principles of care concerning recovery support services for this population. Young adults in recovery from SUD can benefit from a variety of support services throughout the process of recovery. These services take place in both traditional clinical settings and settings outside the health system, and they can be delivered by a wide variety of non-professional and para-professional individuals. This article communicates fundamental points related to guidance, evidence, and clinical considerations about three basic principles for recovery support services: (1) given their developmental needs, young adults affected by SUD should have access to a wide variety of recovery support services regardless of the levels of care they need; (2) the workforce for addiction services for young adults should benefit from the inclusion of individuals with lived experience in addiction; and (3) recovery support services should be integrated to promote recovery most effectively and provide the strongest possible social support.

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Keywords

Young adults; recovery support services; social ecological model; recovery capital; substance use disorder

Introduction

Young adulthood (ages 18 to 25 years) is defined by significant transitions from the dependence of adolescence to the independence and responsibilities of adulthood (Arnett, 2000; Cleveland and Goldstein, 2019). Substance use peaks during young adulthood (Kandel and Logan, 1984), and a significant body of research exists regarding factors associated with its onset, such as unemployment, lower education, and noncustodial parenthood (Merline et al, 2004; Beman, 1995; Kandel, 1982). However, less attention has been paid to the unique needs of young adults in recovery from substance use disorders (SUD) and how best to promote the recovery process for this particularly vulnerable population (Smith, 2017).

Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential (SAMHAS, 2016). According to SAMHSA, a successful recovery hinges on four key dimensions: 1) overcoming or managing one's condition and symptoms; 2) having a stable and safe place to live; 3) conducting meaningful daily activities and having the independence, income, and resources to participate in society; and 4) having relationships and social networks that provide support, friendship, love and hope. SAMHSA's definition of recovery implicitly recognizes the complex interplay among the individual, family, community, and other social factors that influence the trajectory of recovery.

Recovery capital is the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from alcohol and other drug problems (White and Cloud, 2008). Recovery capital is conceptually linked to a broad range of recovery-related terminologies such as natural recovery, solution-focused therapy, strengths-based case management, recovery management, resilience, and the ideas of overall wellness and global health) (Cloud and Granfield, 2008). This comprehensive view of recovery resources has been further characterized in three types of recovery capital including personal capital (an individual's physical and human capital such as physical health, financial assets, health insurance, safe shelter, food security, transportation, education/vocational skills, self-esteem and confidence), family/social capital (intimate relationship, family and kinship relationships, and social relationships such as partner and family support), and community capital (community-level attitudes, policies, and resources such as education and training, employment, housing, legal counseling, role models, and culturally-prescribed pathways of recovery) (Cloud and Granfield, 2008). The resources, or capital, that an individual person needs depends on the severity of her substance use disorder and the resources she already has available. From a social ecological perspective (Bronfenbrenner, 1979), it is necessary to act across multiple levels and dimensions to sustain full recovery over time and ensure

long-term success. SAMHSA has advanced the framework of Recovery Oriented Systems of Care (ROSC), which proposes a multi-system, person-centered continuum of care where a variety of coordinated support services are tailored to patients' recovery stage, recovery pathway, and needs (Clark, 2008).

The focus of recovery support services is responsive to calls from the National Academy of Medicine for a change from an acute care model to one typically used for chronic conditions (Institute of Medicine, 2005) The full range of recovery support services is intended to address the multitude of life areas in response to patients' changing needs. Conceptually, the dimensions of recovery support services call for promoting partnerships with people in recovery from SUD and their family members to promote individual, program, and system-level approaches that foster health and resilience. These approaches include helping young adults with SUD be well, manage symptoms, and achieve and maintain abstinence; increase housing to support recovery; reduce barriers to employment, education, and other life goals; and secure necessary social supports in an individual's chosen community.

Considering this array of recovery support services and potential delivery systems to support them, a group of experts was convened as part of the Grayken Center Young Adult Summit to derive principles of care related to recovery support services. This article communicates fundamental points related to guidance, evidence, and practice considerations about three basic principles for recovery support services to promote young adult recovery.

Principle 1:

Given their developmental needs, young adults affected by SUD should have access to a wide variety of recovery support services regardless of the levels of care they need.

Guidance

A key premise underlying recovery support services is that SUD is a chronic disease (Dennis and Scott, 2007). As a result, clinicians caring for young adults with SUD should recognize that the recovery process takes place primarily outside of conventional, medical system-based treatment settings. A treatment model that focuses on acute care, or that takes place in isolation from other community-based services, is at odds with longitudinal studies that indicate that more than half of patients entering publicly funded addiction programs require multiple episodes of treatment over several years to achieve sustained recovery (Dennis et al., 2007), and that the recovery process is marked by cycles of recovery, relapse, and repeated treatment episodes (McLellan et al, 2000; Scott et al, 2005). This is particularly true for young adults (White and Godley 2007).

In part because social contexts that give rise to an individual's substance use can remain largely unchanged, challenges can remain long after abstinence is attained, particularly with respect to family and social relationships, housing, education and employment. Clinicians should recognize that regardless of the level of treatment received, young adults without access to a variety of recovery social services risk experiencing a prolonged and often insufficient recovery, which delays or prevents full integration into their own communities. Recovery social services, when used appropriately for young adults, can link young adults

to needed resources, empower them to sustain recovery management, and help them regain independence.

Evidence

An exploratory study among individuals who entered – but subsequently left – publicly funded urban addiction treatment programs found that 54% expressed unmet needs for social services, particularly in areas of job training, stable housing, and further assistance with housing (Laudet, Stanick, & Sands, 2009). Data among community samples in abstinent recovery found that employment was the second most frequently mentioned priority at all stages of recovery (Laudet & White, 2010). Initiatives from SAMHSA yielded valuable knowledge about the typology and implementation of the recovery support services. For example, the Recovery Community Services Program was a SAMHSA-funded initiative consistent with a socio-ecological framework that includes sober and stress management, building constructive family and social relationships, peer coaching and mentoring, education and skill training (including help with housing), as well as enhancing access to system-level resources such as primary and behavioral care, child welfare, and criminal justice systems (Kaplan, Nugent, Baker, Clark & Veysey, 2010).

While there is good empirical evidence of formal professionally-directed formal aftercare model in reducing SUD among adolescents and young adults (Kaminer et al 2008; Burleson et al 2012), informal peer-based social network support also contributes to part of “recovery communities” for recovery (Fisher 2014). A randomized trial of volunteer recovery support of adolescents following residential treatment discharge found better engagement in recovery management activities, including sobriety related activities and self-help, and increases in the number of pro-recovery people surrounding the recovering individuals (Godley et al, 2019). Another observational study found improvement in employment status was associated with SUD post-treatment recovery outcomes including abstinence and reduced days missed from work due to substance use (Sahker et al, 2019). This adds to the literature primarily based on trials and systematic reviews about the link between employment and recovery outcomes (Defulio et al 2009; Room, 1998; Henkel, 2011; Brewer et al, 1998). A review study found a moderate level of evidence that recovery housing is associated with improvements in functioning including employment and criminal activity, and positive substance use including abstinence (Reif et al 2014). Younger members participating in a substance abuse recovery housing intervention for six or more months experienced better outcomes in terms of substance use, self-regulation, and employment (Jason et al, 2007).

For young adults, recovery support provided within the education setting specifically can be an important source of social support. Structured educational recovery support services have been growing in the high school and college settings since the 1970s. There is substantial heterogeneity in the structure of recovery high schools and collegiate recovery programs, but the commonality is that both create environments to support relationships between same-age peers with similar recovery goals. Recovery high schools are typically small programs embedded within another school or part of a set of alternative schools (Moberg 2008). The schools provide academic courses that are often self-paced, and therapeutic support

which generally includes individual therapy and support groups. In a quasi-experimental study, adolescents with substance use disorders who attended a recovery high school was associated with an increased likelihood of abstinence, compared to those who did not attend a recovery high school (Finch 2018).

Collegiate recovery programs facilitate social support for college students in recovery, but tend not to provide separate educational experiences (Brown 2018). Services range from sponsoring on-campus mutual help meetings to structured programs that includes a physical space where counseling and social events are hosted. There are no studies evaluating outcomes associated with these programs, but a survey of student's experiences identified that students were primarily motivated to participate in a college recovery program because of a need for a supportive peer network (Laudet 2016).

Practice considerations

There is general consensus that young adults with SUD require developmentally appropriate approaches for treatment and recovery (Spear & Skala, 1995; Deas et al, 2000). While factors vary in influencing relapse and recovery (including addiction severity, individual motivation and skills, co-occurring mental health conditions, family environment, and the availability of supportive peers), formal inpatient adolescent and young adult treatment programs tend to be short, lasting between one and three months (Godley et al, 2002). When the treatment ends, young adults return to their communities often unprepared for the competing demands of social integration (Gonzales et al, 2012). Therefore, practitioners should recognize that regardless of the levels of care the patient needs, young adults' recovery is influenced by many individual, family, and community-level factors. Practitioners should work with young adults to adopt a patient-centered approach to care that addresses the physical, psychological, interpersonal, and community factors that affect the relapse and recovery.

Principle 2:

The workforce for addiction services for young adults should benefit from the inclusion of individuals with lived experience in addiction.

Guidance

In addition to evidence supporting the benefit of comprehensive recovery support services, evidence suggests there may also be benefits to having peer workers in the workforce to support youth recovering from drug abuse (White 2009). Typically, support recovery services provided by those with lived experience in addiction do not replace the need for formal treatment or clinical guidance; rather, they offer an enhancement to treatment that enhances the likelihood of sustained recovery. Peers with lived experience can provide support to substance-using persons by sharing experiences and knowledge, offering understanding, and suggesting coping strategies. Personal, lived experience allows the peer recovery support provider to be "experientially credentialed" (White 2009) and infuses interactions with a sense of mutuality designed to promote connection and hope (SAMHSA, 2017). Often, peer workers with lived experience in addiction are well positioned to motivate

patients to cope with their challenges such as skills training, employment, and social integration (Tracy et al 2012).

Peer workers may work on a volunteer basis or be paid. When compensation is involved, the pay can vary widely (SAMHSA, 2008). Peers work in a variety of settings, ranging from recovery community organizations where educational, advocacy, and sober social activities are organized, to churches or other faith-based institutions, to recovery residences, the criminal justice system, drug courts, health service centers, and addiction and mental health treatment agencies (SAMHSA, 2012). The function of the peer recovery support often matches the vision and mission of the individual settings and the needs of community. Peer workforce has been shown to be a key component of the community reinforcement approach, demonstrated valued social roles in helping youth with drug abuse achieve recovery and maintain abstinence (Smith et al 2001; Meyers and Smith, 1995).

Evidence

White defined “peer-based recovery support” as the process of giving and receiving non-professional, non-clinical assistance to achieve long-term recovery (White 2009). Other similar terminologies are used in the literature to describe peer-related support and contexts, including peer support, peer support group, peer provider, and peer mentor (Tracy et al, 2012; SAMHSA 2016). Extensive literature has shown peer support groups as a key component of existing addiction treatment and recovery approaches, including residential and sober living, 12-step programs, and treatment programs in community settings. Sober living houses are drug-free living environments for a group of peers to live and recover, which rely on mutual sobriety support and participation. A randomized trial found an Oxford House intervention was associated with a significant decrease in substance use following discharge from inpatient treatment, as compared to a usual care condition (Jason et al., 2006). Twelve-step programs such as Alcoholics Anonymous (AA) is the most popular peer support recovery approach held outside the formal treatment setting for addiction (Humphreys, 1997). AA affiliation has been linked to better self-efficacy, healthy coping, and reductions in alcohol and drug use (Humphreys et al 1999; McKellar et al 2003).

Peer support services within treatment and community settings vary substantially in modalities of delivery, including in-person self-help groups, peer-run or operated services, peer partnerships, peer specialists, case managers, advocates in health care settings, and Internet support groups (Solomon 2004). Two review studies found that active engagement in peer support groups has shown to be a key predictor of treatment retention, improved relationships with treatment providers, social support, and reduced relapse rates (Reif et al., 2014; Bassuk et al., 2016). Methodological limitations include small sample sizes, absence of appropriate comparison groups, and the inability to disentangle the effects of peer recovery support from other treatment and support activities. More rigorous investigations are needed to assess the effectiveness of peer support recovery programs, with special attention to the advantages of peer support integration within the substance use treatment continuum.

Practice considerations

Although there are limited data on the effectiveness of peer support recovery services for treating opioid use disorders among emerging youth, the literature on the effectiveness of peer support as an augmentation to treat alcohol and other drugs for the general population confirms peer support as a key and popular component for successful practice. Clinical considerations could focus on exploring the multitude of specific services types and modalities including internet-based peer support, and how to integrate with formal treatment services in various community settings.

Barriers do exist. When implementing in a unique setting, gaining a rapport with that community can present a significant challenge unless guided by key informants from the recovery community. Recovery Community Organizations can serve as a hub to connect to these services, reducing the access barriers. When referring to support services, practitioners are in a unique position to enlighten and influence agencies and states to recognize the value of these services and advocate for the creation of certifications for peer workers, their inclusion in Medicaid reimbursement, or other measures to support the uptake of these workers.

Principle 3: Recovery support services should be integrated to promote recovery most effectively and provide the strongest possible social support.

Guidance

The goal of integrated care is broadly to enhance the quality of care and quality of life, patient satisfaction and system efficiency for those with complex, long term problems across multiple services, providers and settings (Kodner and Spreeuwenberg, 2002). In the context of young adults recovery support services, integration of services can be thought of as a means of delivering health and social support services by coordinating the efforts of services to respond more efficiently and effectively to the multiple and complex needs of youth with SUD. Integration of care should go beyond coordination between formal treatment services (i.e., detoxification and residential rehabilitation) to ensure greater continuity of care occurring between systems of formal treatment and recovery support services that reflect individual patient’s needs and community resources. Typically, concerted methods and models on funding, administrative and organizational, service delivery, and clinical levels are needed to create and maintain integrated services. Clinicians who treat young adults with SUD are in a unique position to gather frontline data on SUD among young adults. They can utilize a screening tool to assess health-related social needs, work closely with case managers to develop a patient-centered care plan, and refer patients to social services. Clinicians can be strong advocates for co-located services, staff training, and information sharing. Hospitals and health centers can promote partnerships between their institutes and social services entities, share common agency goals, and inter-departmental collaboration (Savic et al, 2017).

Evidence

There is growing evidence that health care and other social services can be integrated into treating and supporting patients with SUD. There is success in integrating harm reduction strategies such as naloxone training and medication treatment to reduce SUD harms (Walley et al 2013; Bagley et al., 2020). Systematic reviews generally report that clients receiving integrated care with both SUD and mental health counseling demonstrate improved SUD and mental health outcomes – at least when mental health conditions are not severe (Donald et al 2005). Reviews of studies on patients with severe mental health conditions, however, have demonstrated inconsistent results (Drake et al 2008; Hunt et al 2013).

With respect to integrating SUD and support services, a pragmatic clinical trial of coordinated care management found that clients who received integrated care used more social services and demonstrate greater abstinence rates as compared to standard care clients (Morgenstern et al, 2009). A meta-analysis of integrating maternal substance use treatment and pregnancy, parenting, or child services found reduced substance use associated with integrated care (Milligan et al 2010). Among a small longitudinal cohort of homeless youth suffering from a first episode of addiction in Canada, an intensive outreach intervention integrating access to housing support organizations, mental health services, and collaborative learning among providers was effective in improving youth's housing stability, functioning, and illness severity (Doré-Gauthier et al, 2019). Recent review studies also demonstrating emerging interventions integrating recovery support services to include skills training (O'Connnell etal,2020), employment and placement (Harrison et al, 2019; Sahker et al, 2019), and budgetary service (Tompkins et al, 2019).

Practice considerations

Because complex health-related social needs are common among patients with SUD, case management was a common and practical model of service delivery for integrated care (Scharf et al., 2013; Vanderplasschen et al., 2019). Case management can be intensive and often requires a long-term commitment which may limit the ability of case managers to accept new clients. Pooling resources from community-based agencies to coordinate services offering, match with client needs, and enhance referral system may overcome constraints of case management.

One major obstacle to integration is organizational boundaries. A survey of 270 agencies offering services for women with addiction problems found strong inter-agency relationships contributed to the success of integration (Sword et al., 2013). While formal inter-agency relationship helps define accountability, informal relationship through the development of professional network and collaborative learning opportunities can foster knowledge sharing around a common purpose.

At a clinical level, screening for health related social needs enables the identification of the need for support services, although such screening tends to focus on the general population. In addition to the approaches of bringing the Screening, Brief Intervention, and Referral to Treatment (SBIRT) into a pediatric medical setting and further integrating substance use counseling and brief interventions into school and college settings (Sterling et al, 2012),

providing screening for health related social needs will help maximize the accessibility of comprehensive and integrated support services for youth with SUD.

There is an increased use of mHealth technology to support substance use recovery among youth (Gonzales et al 2016; Nesvåg and McKay 2018). Given the ubiquity of mobile phone use and improved engagement among young adults, more evaluation is needed to assess practical feasibility and effectiveness of using mobile technology to provide integrated services and enhance uptake of potentiating timely and needed interventions to promote support and recovery among young adults.

Conclusion

In light of multiple and complex needs for youth recovering from SUD, it is critical to enhance the variety of recovery support services being offered, including peer workers to enhance experiential credibility, and to address how best integrate these recovery services suitable for young adult's individual needs as well as the resources and needs of the community. Table 1 summarizes select evidence from rigorous studies that support a comprehensive array of recovery support services. Although the principles in this document derive from the research literature that may tend to focus on the general population or on a certain type of substance (i.e., alcohol) and not necessarily on opioid use among young adults, these principles should serve as a useful guiding roadmap for overcoming barriers and achieving better efficiency and quality of care from a social ecological perspective.

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Table 1.

Summary of Select Evidence

Content area	Year	Author(s)	Sample	Setting	Study period	Design	Outcome	Main findings	Comments on scientific rigor and clinical considerations
Housing	2006	Jason et al	N=150 with substance use history in an urban setting	Either an Oxford House or usual after-care condition (i.e., outpatient treatment or self-help groups) after they had received inpatient treatment for substance abuse	24-month study period with baseline and interviews every 6 months	RCT	Substance use; criminal activities; employment status	Significantly lower substance use, significantly higher monthly income, and significantly lower incarceration rates	Rigorous RCT demonstrating the effect of mutual help-oriented recovery housing in reducing substance use, crime activities, and improve employment for people with substance use history
Social services	2009	Morgenstern et al	N=421 in a large city	Randomized to coordinated care management involving various social services and coordinated referral system vs. usual care	Baseline, 1, 3, 6 and 12 months follow interviews	Practical Clinical Trial	Social services use; abstinence status	Broad and significantly more services use (e.g., addiction, mental health, employment, and basic needs), and significantly higher rate of abstinence among those receiving coordinated care	A practical clinical trial showing significant uptake of recovery support services and abstinence increase as a result of a coordinated system integrating social services with substance abuse treatment
Peer support	2016	Bassuk et al	N=9 studies	US studies in PubMed, PsychInfo, and Web of Science with search terms: peer involvement; alcohol or drug addiction; peer led recovery interventions.	English literature of primary empirical quantitative studies between 1998 and 2014	Review study	Substance use (primary outcome); service utilization, mental health, criminal justice status, quality of life	Despite limited evidence involving strong methodological rigor, peer support was found to be beneficial and associated with improved recovery outcomes and reduced substance use.	Extensive review study summarizing evidence of peer support recovery in reducing substance use and other recovery related outcomes, with extensive recommendations for strengthening further studies on peer-delivered recovery support services
Volunteer support	2019	Godley et al	N=402 aged 12-20 and discharged from residential treatment	Randomized to either 9 months of post-treatment Volunteer Recovery Support for Adolescents (VRSA), or continuing care services as usual	Assessed over 12 months post-discharge	RCT	Pro-recovery peers, recovery management activities, substance use, and remission	Significant direct effects to have more involvement with pro-recovery peers and recovery management activities, and indirect effects on reducing substance use and increasing remission.	Rigorous trial involving a large sample and demonstrating improvements in both proximal (pro-recovery activities) and distal outcomes (reduced substance use)
Case management	2019	Vanderplasschen et al	N=31 studies	Embase, Web of Science, MEDLINE (PubMed), the Cochrane Drugs and Alcohol Group Specialized Register and Cochrane Central	English literature from Jan 2006 to May 2017	Review meta-analysis	Treatment related outcomes; personal functioning outcomes	Case management is more effective than treatment as usual conditions for improving outcomes, but this effect is significantly larger for treatment-related tasks than for personal	Meta-analysis on a large number of trial studies provides a rigorous synthesis of the effect of case management for integrated support services.

Content area	Year	Author(s)	Sample	Setting	Study period	Design	Outcome	Main findings	Comments on scientific rigor and clinical considerations
				Register of Controlled Trials				functioning outcomes. Case management can be an important supplement to available services for improving linkage and retention	