NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Recovery/Resilience, System of Care and Person-Centeredness in Services for Youth and Their Families

Supplemental Reading

January 2011

The Recovery Revolution:
Will it include children, adolescents, and transition age youth?

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Executive Summary

Systems transformation efforts to shift addiction treatment from a model of acute stabilization to a model of sustained recovery management and to nest addiction treatment within a larger recovery-oriented system of care are underway at federal, state, and local levels, but these innovations to date have focused on the redesign of adult services. This paper explores the potential and limitations of recovery as an organizing concept for services to children, adolescents, and transition age youth, and offers recommendations on how services for these populations can be integrated into recovery- and resiliency-focused, behavioral health care systems transformation efforts.

Recovery Revolution Defined

- Since 2004, the City of Philadelphia has been engaged in a recovery-focused behavioral health care systems transformation process that has mobilized the community around a recovery vision and begun aligning concepts, service practices, and contexts (e.g., regulatory policies, funding mechanisms) to support that vision.
- Federal, state, and local behavioral health policy and planning bodies are now evaluating the extent to which recovery can be used as an organizing concept for child and adolescent (C & A) services.
- There is growing consensus to create a recovery-oriented system of care for youth that is family-driven, developmentally appropriate, culturally nuanced, highly individualized, and focused on youth resilience, strengths, and empowerment.
- Questions remain about the potential advantages and disadvantages of the recovery concept applied to C & A services and how that concept can be integrated with the existing concepts that have been used to guide the design of C & A services.
- These questions will be explored as they relate to *children*, *adolescents*, and *transition age-youth.*

Historical Context: Recovery and Age of Onset of Alcohol and Drug Use

- The most socially and clinically significant American drug trend of the past century is the lowered age of onset of alcohol and other drug use.
- Lowered age of initial AOD use is linked to greater risk of developing a substance use disorder, the speed of problem progression and severity of consequences, and greater levels of post-treatment relapse.
- The average age of onset of AOD use of adolescents entering addiction treatment is now below age 13.
- The concept of recovery is more applicable to children, adolescents, and transition-age youth now than at any previous time in the country's history.

Family Recovery

- Child development can be adversely affected by AOD-related problems of their parents or siblings, and children in AOD-affected families are at increased risk for developing such problems as well as experiencing other adverse developmental outcomes.
- The recovery of a parent with AOD-related problems enhances the health and developmental outcomes of his or her children.
- Interventions are available that enhance the recovery and resilience of children negatively impacted by parental substance dependence.

Recovery of Adolescents and Transition Age Youth

- In 2008, 8% of youth aged 12-17 and 21% of transition age youth met diagnostic criteria for a substance use (alcohol or illicit drugs) disorder, but less than one in ten youth received specialized addiction treatment.
- There are more than 4,900 treatment programs that specialize in the treatment of adolescent substance use disorders. There has also been an increase in youth-focused recovery mutual aid meetings.
- The earlier the intervention for a substance use disorder (in terms of both age and months/years of use), the better the long-term recovery outcomes.
- There are evidence-based, brief therapies that are effective for many substance-involved adolescents, but most adolescents are precariously balanced between recovery and relapse in the months following such therapy.
- Recovery stability is enhanced by sustained post-treatment monitoring, support, and if needed, early re-intervention, but such extended care and support is rare.
- The concept of recovery seems to be a viable one for adolescents seeking to reconstruct their lives following significant and sustained AOD-related problems.

Conceptual Frameworks for Organizing Child and Adolescent Services

- The concepts of "system of care," "wraparound services," "positive youth development," and "resilience" have served as organizing frameworks for C & A services in recent decades.
- Resilience is the achievement of positive developmental outcomes in spite of personal and environmental risk factors.
- Resilience-based systems of youth development seek to reduce risk factors and increase protective factors at personal, family, and environmental levels.
- Resistance is: 1) an innate hardiness that allows one to be exposed to an infectious agent without becoming ill, and/or 2) the act of desisting or ceasing AOD use as an act of cultural or political survival.
- Recovery from a substance use disorder entails three critical ingredients: sobriety, global health (physical, cognitive, emotional, relational, spiritual), and citizenship.
- These elements of recovery have yet to be fully defined for youth.

Recovery Management and Recovery-Oriented Systems of Care

- *Recovery management* (RM) is a philosophy of organizing addiction treatment and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery.
- *Recovery-oriented systems of care* (ROSC) encompass the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families affected by AOD problems and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes.
- Approaches to RM and ROSC for adults and for youth share many elements in common.
- Efforts are currently underway (as this report indicates) to identify what distinctive changes in services for children, adolescents, and transition age youth occur within the movement to RM and ROSC.

Shared Characteristics of Organizing Concepts

- Rather than think of recovery and resilience in either/or terms, it may be helpful to think of systems transformation guided by both resilience and recovery.
- Child and family advocates in many places have embraced these concepts as complementary.

Primary Prevention, Early Intervention, Treatment, and Recovery Support

- Addiction treatment and recovery support services for parents constitute a strategy of prevention for their children.
- These strategies can be further amplified by involving children in the treatment of their parent and by providing specialized services designed to enhance the child's recovery from the developmental insults of parental addiction and to enhance the child's future resilience and resistance related to AOD-related problems.
- The treatment of every adult parent should include child-focused prevention and early intervention services aimed at breaking the intergenerational transmission of AOD-related problems.
- RM and ROSC involve an integration of primary prevention, early intervention, treatment, and recovery support services.

Recovery Concept and Children: Advocates

- Advocates of applying the recovery concept to C & A services extol the concept's holistic, developmental perspective; emphasis on hope, empowerment, and choice; integration of spirituality as a healing/protective force; emphasis on thriving rather than just symptom remission; compatibility with system of care and positive youth development approaches to youth service design; inclusion of such issues as historical trauma and social stigma; and its emphasis on the role of social connectedness in adolescent health.

Recovery Concept and Children: Critics

- Critics of applying the recovery concept to C & A services contend that recovery: is misapplied to children because of its meaning of returning to a previous level of functioning; brings with it the social stigma attached to addiction; lacks a holistic, developmental perspective because of its "disease" trappings; and works only if integrated with the concept of resilience.

The Philadelphia Focus Groups

- Focus groups with providers, parents, and youth felt that recovery and resilience were compatible concepts that both called for developmentally-informed models of care, family inclusion/direction and leadership, peer support and leadership, a continuum of support, community integration and mobilization of community recovery/resiliency support resources, trauma-informed care (and addressing violence within the trauma framework), and culturally competent care.
- A group of youth much discussed in the Philadelphia focus groups was transition age youth who were "aging out" of the child service system with little transitional support when they were no longer eligible to continue receiving services. It was hoped that new approaches to such transition planning could be developed given the ROSC emphasis on long-term, stage-appropriate recovery support.

The Voices of Youth

- Voices from the youth focus groups pleaded for a system of care that would see them as individuals rather than a disorder and relate to them from a position of respect and authenticity.

Summary and Recommendations

- The report ends with a set of recommendations in the following areas: concepts and language of systems transformation, representation and leadership, recovery visibility of youth, collaboration and partnership, a continuum of (personal/family/community) recovery support, practice guidelines, assessment and treatment/recovery planning, recovery-focused treatment, youth-focused peer recovery culture, and evaluation of effects of systems transformation on C & A and C & A Service Providers.
- These recommendations are intended as a framework for continued discussions regarding the future of C & A services within the City of Philadelphia.

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> *Comprehensive systems to facilitate recovery for adults with substance abuse and/or mental health concerns have been conceptualized and operationalized in a number of states and communities across the United States and in other countries. To date there has been little discussion or research on how these adult-focused concepts apply to adolescents.*[1]

The governing concepts of the addictions field are rapidly shifting from a focus on pathology and professional treatment to the lived experience of long-term recovery. Phrases such as *recovery management* (RM) and *recovery-oriented systems of care* (ROSC) reflect a paradigmatic shift in the design and delivery of addiction treatment. *Systems transformation* efforts reflecting this new long-term recovery perspective are underway at federal, state, and local levels.[2] These initiatives are generating considerable excitement within the addictions field, but are to date limited by their emphasis on the redesign of adult addiction treatment and innovations related to peer-recovery support services for adults. The purpose of this paper is to explore the potential and limitations of recovery as an organizing concept for services to children, adolescents, and transition age youth. The paper explores a variety of potential organizing concepts and ends with a series of recommendations on how children, adolescent, and transition age youth services can be fully integrated into recovery- and resiliency-focused, behavioral health care systems transformation efforts.

Recovery Revolution Defined

For the past five years, the City of Philadelphia has been at the center of two national shifts in behavioral health care. The first is the emergence of *recovery* as an organizing concept for the design and delivery of addiction treatment and other behavioral health care services.[3] The second is an effort to extend addiction treatment

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[1] Cavanaugh. D., Goldman, S., Friesen, B. and Bender, C. (2008). *Designing a recovery-oriented care model for adolescents and transition age youth with substance use and co-occurring mental health disorders*. Prepared for the CSAT/CMHS/SAMHSA Recovery Consultative Meeting, November 13-14, 2008.

[2] White, W. (2008). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care*. (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

[3] Gagne, C. A., White, W., & Anthony, W. A. (2007). Recovery: A common vision for the fields of mental health and addictions. *Psychiatric Rehabilitation Journal, 32*(10), 32-37. White, W. (2005) Recovery: Its history and renaissance as an organizing construct. *Alcoholism Treatment Quarterly, 23*(1), 3-15.

from models of acute biopsychosocial stabilization or palliative care to a model of active and sustained recovery management[4] and to nest these services within larger "recovery-oriented systems of care."[5] The contextual influences that set the stage for this "recovery revolution" include the growth, philosophical diversification, and geographical dispersion of recovery mutual aid societies (including online recovery communities); the cultural and political awakening of people in recovery from behavioral health disorders via a renewed advocacy movement; and increased recovery community building activities, e.g., the growth of grassroots recovery community organizations, community recovery centers, recovery homes, recovery schools, recovery industries, and recovery ministries.[6]

In 2004, the City of Philadelphia committed itself to a major recovery-focused transformation of its behavioral health care system under the new leadership of Dr. Arthur Evans, Jr. Table 1[7] identifies several distinguishing elements of the "Philadelphia Model" of behavioral health care systems transformation.

Table 1: Creating a Recovery-Oriented System of Care: The Philadelphia Model

System Dimension	Philadelphia Model
Recovery Vision	Resources are allocated to support the recovery vision (wellness, wholeness, quality, and meaningfulness of life) for individuals, families, and neighborhoods. All policy-makers and clinical decision-makers undergo ongoing, recovery-focused training and supervision.
Varieties of Recovery Experience	Service planners and providers acknowledge the legitimacy of multiple pathways and styles of long-term recovery from behavioral health disorders and promote a philosophy of choice within their service relationships.
Systems Level Recovery Management	Behavioral health care is managed by a publicly-owned entity responsible for the effective stewardship of public behavioral health care dollars and the strategic allocation of resources to support the long-term recovery of individuals and families whose lives have been disrupted by behavioral health disorders.
Behavioral Health	Recovery is used as a conceptual bridge for the increased

White, W. (2008). Recovery: Old wine, flavor of the month or new organizing paradigm? *Substance Use and Misuse, 43*(12&13), 1987-2000.

[4] McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13), 1689-1695. 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.

[5] White, W. (2008a). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care*. (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

[6] White, W.L. (2007). A recovery revolution in Philadelphia. *Counselor*, *8*(5), 34-38.

[7] Excerpted from McLaulin, B., Evans, A.C., & White, W. (2009). The role of addiction medicine in a recovery-oriented system of care. Unpublished manuscript.

Care Integration	integration of professionally-directed mental health services, professionally-directed addiction treatment services, peer-based recovery support services, and primary health care.
Systems Integration	Federal, state, county, and municipal resources are coordinated to generate increased resources, strategically allocate resources, and provide regulatory relief.
Service Accessibility	Service entry is accessible, efficient, respectful, and warmly welcoming: all system elements are devoted to the goal of rapid and gracious service engagement.
Global Assessment	Assessment is comprehensive, strengths-based, continual, family-inclusive, and encompasses assessment of each client's recovery environment.
Service Quality and Responsiveness	Services are developmentally appropriate, gender-specific, culturally competent, trauma-informed, family-focused, and evidence-based.
Indigenous Resources	Services at all levels of care include assertive linkage to indigenous communities of recovery (recovery support groups) and recovery community service institutions (recovery community centers, recovery homes, recovery ministries, recovery advocacy organizations).
Continuity of Support	All primary treatment services are followed by post-treatment monitoring and support, stage-appropriate recovery education, active recovery coaching, and when needed, early re-intervention.
Systems Performance Monitoring and Evaluation	Recovery-focused systems performance data and the ongoing guidance of key stakeholders are used to guide the continued systems transformation process.
Systems Health	The ability of a behavioral health care system to enhance the health of those it serves is only as good as the health of service providers and the service infrastructure. Active efforts are made to enhance the health and performance of service providers and service organizations.

Table 2[8] summarizes key ideas that have guided this process of system-wide change.

Table 2: Philadelphia System Transformation Implementation Principles/Strategies

1. Partnership: Relationships within the system—from service relationships to institutional relationships—shift from authority-based to respect-based and emphasize stakeholder representation, participation, collaboration, and multi-directional communication.

[8] Excerpted from McLaulin, B., Evans, A.C., & White, W. (2009). The role of addiction medicine in a recovery-oriented system of care. Unpublished manuscript.

2. New Ideas, New Language, New Technologies: Systems transformation is driven by a set of kinetic (change-eliciting) ideas, a new language, and new planning and service technologies that are recovery-focused.
3. Core Values: Decisions are based on the values of hope; choice; empowerment; peer culture, support, and leadership; partnership; community inclusion/opportunities; spirituality; family inclusion and leadership; and a holistic/wellness approach.
4. Openness and Transparency: Decisions at all levels of the system—from clinical decisions to policy and funding decisions—are transparent and consistent with previously defined values, policies, and plans.
5. Planned Synergism: Multiple staged initiatives are used to complement one another to achieve magnified effects.
6. Minimalism: Existing structures are used or renewed when possible; the goal is the minimal level of organization needed to achieve a task; wide use of short-term ad hoc groups to study, decide, design, create, and disband; preference for development and use of local expertise.
7. Management of Resistance: Resistance to change at all levels is viewed as a normal part of the systems change process and is actively managed.
8. Change Facilitation: System transformation is facilitated by training, process consultation, and technical assistance at all levels of the service delivery system.

As these tables illustrate, the behavioral health care systems transformation process in Philadelphia involves efforts aimed at conceptual alignment (core values and principles), contextual alignment (system policies and relationships), and practice alignment—all directed toward support of long-term recovery for individuals and families. The history, goals, and strategies of this process have been described in a series of earlier publications.[9]

Those readers with any significant tenure in health and human service systems will have witnessed the rise and fall of many newly proclaimed organizing concepts. Seen in this historical context, it is difficult to determine whether an emerging concept

[9] Achara-Abrahams, I., Kenerson, J., & Evans, A.C. (in press). Recovery-focused behavioral health system transformation: A framework for change and lessons learned from Philadelphia. In J. Kelly, & W. White (Eds.), *Addiction recovery management: Theory, science and practice*. Totowa., New Jersey: Humana Press, Inc. DBH/MRS (2007). *Recovery-focused transformation of behavioral health services in Philadelphia: A declaration of principles and a blueprint for change*. Philadelphia: Department of Behavioral Health and Mental Retardation Services. Retrieved from http://www.phila.gov/dbhmrs/initiatives/index.html. DBH/MRS (2007). *An integrated model of recovery-oriented behavioral health care*. Philadelphia: Department of Behavioral Health and Mental Retardation Services. Retrieved from http://www.phila.gov/dbhmrs/initiatives/INT_index.html. Evans.A.C., & Beigel, A. (2006). *Ten critical domains for system transformation: A conceptual framework for implementation, evaluation and adaptation*. Presented at the 16th Annual Conference on State Mental Health Agency Services Research, Program Evaluation & Policy, February, Baltimore, MD. Evans, A. (2007). The recovery-focused transformation of an urban behavioral health care system. Retrieved June 26, 2007 from http://www.glattc.org/Interview%20With%20Arthur%20C.%20Evans,%20PhD.pdf. Lamb, R., Evans, A.C., & White, W. (2009). The role of partnership in recovery-oriented systems of care: The Philadelphia experience. Unpublished Manuscript. White, W.L. (2007). A recovery revolution in Philadelphia. *Counselor*, *8*(5), 34-38.

adds something fundamentally new and valuable or whether it represents a repackaging of old ideas into a new rhetoric.[10] Huffine[11] has raised the question of whether all this new rhetoric—transformation, resilience, recovery, evidence-based practices—constitutes a sign of real change or "the latest ways to put lipstick on a pig"—a cosmetic attempt to beautify failing service systems. Even the most viable of concepts can be lost in the rapidly evolving arena of behavioral health care. Early discussions of systems transformation always evoke feelings of déjà vu and skepticism.

> *I've lived through many administrations and the focus always changes: this month we're supposed to be doing XXX and next month it's YYY. What's going to happen when the focus changes away from recovery and resilience?*[12]

> *Why focus practice guidelines on recovery and resilience? Ten years from now it will be changing. What are we doing to look and plan for future changes?*[13]

An effective organizing concept—what Room[14] calls a "governing image"—must "work" at multiple levels. It must help individuals and families impacted by severe AOD problems make sense of their lives via processes of story construction and storytelling, e.g., "disclose in a general way what we used to be like, what happened, and what we are like now".[15] It must provide a framework to guide the service activities of addiction professionals and recovery support specialists. It must provide a framework for service program design, development, and replication. It must guide policy makers and funding organizations in their macro-level responses to AOD problems. It must help the general public understand, prevent, and respond to such problems. A concept must achieve all of these things across diverse populations and cultural contexts and prove adaptable to changing conditions over time.

It is then not surprising that any governing image used to respond to an intractable problem is inherently unstable.[16] The inevitable imperfection of fit—concepts that work at some but not all of these levels, concepts that work for some populations and within some cultures but not others, concepts that once seemed to work in the past but seem not to presently work—has generated a long history of conceptual instability within the AOD problems arena in the United States.

As the Philadelphia systems transformation process unfolded over the past five years, questions were raised about how this transformation process and the concept of

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[10] Rutter, M. (2006). Implications of resilience concepts for scientific understanding. *Annals of New York Academy of Science, 1094*, 1-12.

[11] Huffine, C. (2006). A new concept of mental health: A focus on strengths. *Iceberg Newsletter*, September, 2-4.

[12] Philadelphia Caregiver Focus Group Participant, 2009

[13] Philadelphia Caregiver Focus Group Participant, 2009

[14] Room, R. (1978). *Governing images of alcohol and drug problems: The structure, sources and sequels of conceptualizations of intractable problems.* Ph.D. Dissertation, Berkeley, CA: University of California.

[15] Alcoholics Anonymous (1939). Proposal to form the One Hundred Men Corporation to publish the book *One Hundred Men*. (Reprinted 1991). Wheeling, WV: The Bishop of Books.

[16] Room, R. (1978). *Governing images of alcohol and drug problems: The structure, sources and sequels of conceptualizations of intractable problems.* Ph.D. Dissertation, Berkeley, CA: University of California.

recovery upon which it rests applies to particular service populations and to particular service modalities. For example:

- Where do primary prevention and early intervention services fit within an ROSC?
- What are the shared and distinguishing characteristics of the concepts of resilience and recovery?
- Where does medication-assisted treatment fit within a recovery-oriented system of care—if at all?
- What roles, if any, do harm reduction (e.g., needle exchange programs) and risk reduction (e.g., DUI programs) play within a recovery-oriented system of care?

As the change process within Philadelphia's behavioral health care system proceeds, there is growing consensus that it needs to go "deeper" (achieving greater depths of change in policies and service practices) and "wider" (embracing service populations and service organizations that have not been fully involved in the transformation process). Questions like the above and the question of how all this relates to children and adolescent services are part of this "deeper" and "wider" process.

The exploration of how systems transformation would affect children and adolescent services was raised early in the transformation process in Philadelphia. A child and adolescent (C & A) subcommittee was created within the Office of Addiction Services Advisory Board to assure the inclusion of goals and objectives related to C & A services.[17] As the transformation process proceeded, greater concern has been voiced about whether the concept of recovery adds anything new to alcohol- and other drug-related (AOD) services for children, adolescents, transition age youth, and their families as well as the future of C & A services within an ROSC.

The concerns raised in Philadelphia about application of the recovery concept to children's services have been mirrored in a series of national meetings. In 2005, the Center for Substance Abuse Treatment (CSAT) hosted a recovery summit that included discussion of the application and potential misapplication of the concept of recovery to adolescents. In November 2008, a national "recovery consultative session" was hosted by CSAT and the Center for Mental Health Services (CMHS) to explore the design of a "recovery-oriented system of care for adolescents and transition age youth" with a substance use or co-occurring mental health disorder. In March 2009, a "national dialogue on families of youth with substance use addiction" engaged affected families and representatives from the Substance Abuse and Mental Health Services Administration (SAMHSA). The latter two meetings addressed problems of service access and quality for substance-affected youth and families, the untoward effects of addiction-related social stigma, and the need for a broad and sustained spectrum of clinical and recovery support services to buttress adolescent recovery through the developmental transition into adulthood. Meeting participants called for a recovery-oriented system of care for youth to be family-driven, developmentally appropriate, culturally nuanced, highly individualized, and focused on youth resilience, strengths, and empowerment.[18]

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[17] See http://www.dbhmrs.org/assets/Forms--Documents/4.2.1.2-OAS-Goals-Objectives-Board-Final-Draft-20080620.pdf

[18] Cavanaugh. D., Goldman, S., Friesen, B., & Bender, C. (2008). *Designing a recovery-oriented care model for adolescents and transition age youth with substance use and co-occurring mental health*

It is noteworthy that the appropriateness and degree of applicability of recovery as an organizing concept for behavioral health services for children and adolescent services tend not to be raised at national, state, or local levels as a major concern until systems transformation processes are well underway.[19] This paper is intended as a stimulus for continued discussion of this issue in Philadelphia and at a national level. It will review scientific studies and professional commentaries on recovery as an organizing concept for services to youth, summarize the results of national and local focus groups that have been hosted to address this question, and offer recommendations to guide our continued work in Philadelphia.

Recovery-related concepts require substantial adaptation across the developmental life cycle.[20] To add specificity to the coming discussions, we will apply these concepts and principles to three distinct developmental groups: *children*, *adolescents*, and *transition age-youth* (also referred to as *emerging adults*).[21] The precise definitions of the three groups vary considerably in the professional and popular literature. In this paper, children will be defined as persons under the age of 13; adolescents will be defined as persons between the ages of 13 and 17; and transition age youth will be defined as persons between the ages of 18 and 25.

Historical Context: Recovery and Age of Onset of AOD Use

There is a long history of concern about alcohol and other drug use among youth in the United States,[22] but the thought of a person in recovery from alcohol or other drug addiction has not historically elicited images of children or adolescents. Until recently, the primary focus on children has been in the arenas of prevention and early intervention and the effects of parental AOD use on children. That focus began to change with the rise of juvenile narcotic addiction following World War II and shifted further during the dramatic rise of youthful drug experimentation in the 1960s and 1970s.[23]

The most socially and clinically significant American drug trend of the past century is the lowered age of onset of alcohol and other drug use.[24] By the early 1990s, more than one third of drug-using youth incarcerated within state-operated juvenile

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disorders. Prepared for the CSAT/CMHS/SAMHSA Recovery Consultative Meeting, November 13-14, 2008.

[19] Davidson, L., O'Connell, M.J., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatric Services, 57*(5), 640-645. Evans, A. (2007). The recovery-focused transformation of an urban behavioral health care system. Retrieved June 26, 2007 from http://www.glattc.org/Interview%20With%20Arthur%20C.%20Evans,%20PhD.pdf. Kirk, T. (2007). Creating a recovery-oriented system of care. In W. White (Ed.), *Perspectives on systems transformation*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

[20] White, W. (2006). Recovery across the life cycle. *Alcoholism Treatment Quarterly, 24*(1/2), 185-201.

[21] Tanner, J.L. (2006). Recentering during emerging adulthood: A critical turning point in life span human development. In J.J. Arnett, & J.L. Tanner (Eds.), *Emerging adults in America: Coming of age in the 21st century* (pp. 21-55). Washington D.C.: American Psychological Association.

[22] White, W. (1999). The history of adolescent alcohol, tobacco and other drug use. *Student Assistance Journal*. *11*(5), 16-22.

[23] White, W., Dennis, M., & Tims, F. (2002). Adolescent treatment: Its history and current renaissance. *Counselor, 3*(2), 20-23.

[24] White, W., Godley, M., & Dennis, M. (2003). Early onset of substance abuse: Implications for student assistance programs. *Student Assistance Journal, 16*(1), 22-25.

facilities reported onset of drug use before age 12 (19% before age 10).[25] A 2005 study of children in foster care found that more than one-third of older children met diagnostic criteria for a substance use disorder.[26] A 2004 study—the largest randomized trial of adolescent treatment ever conducted—revealed that 85% of adolescents entering addiction treatment in the United States begin regular use of alcohol and other drugs before age 15.[27] Seen as a whole, age-related prevalence for substance use disorders sharply rises after age 12 and peaks between ages 18-23, suggesting that the prodromal period for these disorders often spans late childhood and early and middle adolescence.[28] Adding to this import is the finding that the earlier age at which a substance use disorder is treated, the better the long-term outcome.[29]

It is difficult to overemphasize the clinical and social significance of lowered age of onset of AOD use, particularly pre-adolescent onset, and the importance of early prevention and early intervention services. Lowered age of initial AOD use is linked to:

- increased probability of subsequent multiple drug use,[30]
- increased risk of developing a substance use disorder,[31]

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[25] U.S. Department of Justice, Bureau of Justice Statistics. (1994). *Drugs and Crime Facts, 1994.* Retrieved from http://www.ojp.usdoj.gov/bjs/dcf/contents.htm.

[26] Vaughn, M., Ollie, M., McMillen, C., Scott, L., & Munson, M. (2005, January). *Patterns of substance use among older youth in foster care.* Presented at the Society for Social Work and Research Conference, Miami, FL. Amodeo, M., & Collins, M.E. (2007). Using a positive youth development approach in addressing problem-oriented youth behavior. *Families in Society: Journal of Contemporary Social Services, 88*(1), 75-85.

[27] 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.

[28] Dennis, M.L., White, M.K., & Ives, M. (2009). Individual characteristics and needs associated with substance misuse of adolescents and young adults in addiction treatment. In C.G. Luekefeld, T.P. Gullotta, & M. Staton-Tindall (Eds.), *Adolescent substance abuse: Evidence-based approaches to prevention and treatment*. New York: Springer. Enoch, M. (2006). Genetic and environmental influences on the development of alcoholism. *Annals of the New York Academy of Science, 1094*, 193-201. Palmer, R.H.C., Young, S.E., Hopfer, C.J., Corley, R.P., Stallings, M.C., Crowley, T.J., & Hewitt, J.K. (2009). Developmental epidemiology of drug use and abuse in adolescence and young adulthood: Evidence of a generalized risk. *Drug and Alcohol Dependence, 102*, 78-87.

[29] Dennis, M.L., Scott, C.K., Funk, R., & Foss, M. (2005). The duration and correlates of addiction and treatment careers. *Journal of Substance Abuse Treatment, 28*(Supplement 1), S51-S62. M.L., White, M.K., & Ives, M. (2009). Individual characteristics and needs associated with substance misuse of adolescents and young adults in addiction treatment. In C.G. Luekefeld, T.P. Gullotta, & M. Staton-Tindall (Eds.), *Adolescent substance abuse: Evidence-based approaches to prevention and treatment*. New York: Springer.

[30] Kandel, D.B. (1982). Epidemiological and psychosocial perspectives on adolescent drug use. *Journal of American Academic Clinical Psychiatry, 21*, 328-347. McGue, M., Iacono, W.G., Legrand, L.N., & Elkins, L. (2001). Origins and consequences of age at first drink: I. Associations with substance-use disorders, disinhibitory behavior and psychopathology, and P3 amplitude. *Alcoholism: Clinical and Experimental Research, 25*, 1156-1165.

[31] Chou, S. P., & Pickering, R. P. (1992). Early onset of drinking as a risk factor for lifetime alcohol-related problems. *British Journal of Addiction, 87*, 1199-1204. Grant, B. F., & Dawson, D. A. (1997). Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence. *Journal of Substance Abuse, 9*, 103-110. Dennis, M. L., Babor, T., Roebuck, M. C., & Donaldson, J. (2002). Changing the focus: The case for recognizing and treating marijuana use disorders. *Addiction, 97*, S4-S15. Sartor, C.E., Lynskey, M.T., Bucholz, K.K., Madden, P.A.F., Martin, N.G., & Heath, A.C. (2009). Timing of first alcohol use and alcohol dependence: Evidence of common genetic influences. *Addiction, 104*(9), 1512-1518.

- telescoping of the progression of AOD-related problems,[32]
- greater problem severity and complexity—including greater cognitive impairment, liver dysfunction, and probability of a co-occuring psychiatric illness,[33]
- increased risk of school failure,[34]
- increased lifetime risk of accidents while under the influence of alcohol,[35]
- increased risk of perpetration of and victimization by alcohol-related violence,[36] and
- compromised intervention outcomes, e.g., decreased probability of discontinuance of drug use, less help-seeking, and greater post-intervention relapse.[37]

The risks associated with lowered age of onset are not ameliorated by social class or educational achievement and appear to be amplified in the transition between adolescence and young adulthood, e.g., 20.6% of full-time college students meet diagnostic criteria for an alcohol use disorder, and 7.9% meet criteria for a drug use disorder.[38]

Alcohol- and other drug-related problems rise throughout adolescence, peak at a 20% prevalence rate between ages 18-20, and progressively decline over subsequent

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[32] Dewit, D.J., Adlaf, E.M., Offord, D.R., & Ogborne, A.C. (2000). Age of first alcohol use: A risk factor for the development of alcohol disorders. *American Journal of Psychiatry, 157,* 745-750. Kreichbaun, N., & Zering, G. (2000). Adolescent patients. In G. Zering (Ed.), *Handbook of alcoholism* (pp. 129-136). Boca Raton, LA: CRC Press.

[33] Arria, A. M., Dohey, M. A., Mezzich, A. C., Bukstein, O. G., & Van Thiel, D. H. (1995). Self-reported health problems and physical symptomatology in adolescent alcohol abusers. *Journal of Adolescent Health, 16*(3), 226-231. National Institute on Alcohol Abuse and Alcoholism. (2003). Underage drinking: A major public health challenge. *Alcohol Alert, 59,* 1-7. Sobell, M. B., Sobell, L. C., Cunningham, J. C., & Agrawal, S. (1998). Natural recovery over the lifespan. In E. L. Gomberg, A. M. Hegedus, & R. A. Zucker (Eds.), *Alcohol problems and aging* (NIAAA Research Monograph No. 33, pp. 397-405). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.

[34] Gruber, E., DiClemente, R.J., Anderson, M.M., & Lodico, M. (1996). Early drinking onset and its association with alcohol use and problem behavior in late adolescence. *Preventative Medicine., 25,* 293-300.

[35] Hingston, R. W., Heeren, T., Jananka., A., & Howland, J. (2000). Age of drinking onset and unintentional injury involvement after drinking. *Journal of the American Medical Association, 284,* 1527-1533.

[36] Hingston R. W., Heeren T., & Zakocs R. (2001). Age of drinking onset and involvement in physical fights after drinking. *Pediatrics, 108*(4), 872-877. Mrug, S., & Windle, M. (2009). Initiation of alcohol use in early adolescence: Links with exposure to community violence across time. *Addictive Behaviors, 34,* 779-781.

[37] Kandel, D.B., Single, E., & Kessler, R. (1976). The epidemiology of drug use among New York State high school students: Distribution, trends, and changes in rates of use. *American Journal of Public Health, 66,* 43-53. Keller, M., Lavori, P., Beardslee, W., Wunder, J., Drs., D., & Hasin, D. (1992). Clinical course and outcome of substance abuse disorders in adolescents. *Journal of Substance Abuse Treatment, 9,* 9-14. Kessler, R. C., Aguilar-Gaxiola, S., Berglund, P., Caraveo-Anduaga, J., DeWitt, D., Greenfield, S., Kolody, B., Offson, M., & Vega, W. (2001). Patterns and predictors of treatment seeking after onset of a substance use disorder. *Archives of General Psychiatry, 58*(11), 1065-1071. Chen, J., & Millar, W. (1998). Age of smoking initiation: Implications for quitting. *Health Reports, 9*(4), 39-46.

[38] Wu, L., Pilowsky, D.J., Schlenger, W.E., & Hasin, D. (2007). Alcohol use disorders and the use of treatment services among college-age young adults. *Psychiatric Services, 58*(2), 192-200.

decades.[39] In 2007, 133,742 adolescents were admitted to specialty sector addiction treatment in the United States, and a total of 464,323 youth under age 25 were admitted to such treatment.[40] In a recent analysis of 14,776 adolescent addiction treatment admissions, Dennis, White, and Ives[41] found the average age of first AOD use was 12.6 years, with 73% reporting onset of use between ages 10 and 14. This same review found that adolescents had used alcohol and other drugs an average of 3.2 years prior to their admission to treatment. Also noteworthy are studies concluding that certain patterns of adolescent AOD use (e.g., multiple drug use) are more resistant to positive forces of maturing out and are markers for potentially prolonged addiction and psychiatric careers, e.g., drug use disorders of adolescents and a drug use disorder co-occurring with an anxiety disorder or depression.[42]

From a historical perspective, the concept of recovery has greater applicability to adolescents and transition age youth today than at any time in American history. The concern is that most of what we know about recovery is derived from studies of adults. We know very little about the prevalence, pathways, processes, and stages of long-term recovery for adolescents with substance use disorders.[43] That paucity of understanding is reflected in acute care models of intervention into adolescent substance use disorders that lack sustained recovery support and that all too often leave adolescents and families feeling abandoned at discharge.[44] What is needed are long-term studies that illuminate how particular clinical and peer support interventions as well as particular developmental milestones in the transition into adulthood (e.g., leaving home, college, marriage or cohabitation, employment, parenthood) affect trajectories of resilience, addiction, and recovery among high-risk youth.[45]

Family Recovery

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[39] Dennis, M. L., & Scott, C.K. (2007). Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*(1), 45-55.

[40] SAMHSA (2008). National Survey on Drug Use and Health. Trends in Substance Use, Dependence or Abuse, and Treatment among Adolescents: 2002 to 2007. Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA).

[41] Dennis, M.L., White, M.K., & Ives, M. (2009). Individual characteristics and needs associated with substance misuse of adolescents and young adults in addiction treatment. In C.G. Luekefeld, T.P. Gullotta, & M. Staton-Tindall (Eds.), *Adolescent substance abuse: Evidence-based approaches to prevention and treatment*. New York: Springer.

[42] Palmer, R.H.C., Young, S.E., Hopfer, C.J., Corley, R.P., Stallings, M.C., Crowley, T.J., & Hewitt, J.K. (2009). Developmental epidemiology of drug use and abuse in adolescence and young adulthood: Evidence of a generalized risk. *Drug and Alcohol Dependence*, *102*, 78-87.

[43] White, W., & Godley, S. (2007). Adolescent recovery: What we need to know. *Student Assistance Journal*, *19*(2), 20-25.

[44] Center for Substance Abuse Treatment. (2007). *National Summit on Recovery: Conference Report* (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration. *Blamed and Ashamed.* (2001). Alexandria, VA: Federation of Families for Children's Mental Health. 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.

[45] For a representative study, see D'Amico, E.J., Ramchand, R., & Miles, J.N.V. (2009). Seven years later: Developmental transitions and delinquent behavior for male adolescents who received long-term substance treatment. *Journal of Studies on Alcohol and Drugs*, *70*, 641-651.

The concept of *family recovery* has significant applicability to children, adolescents, and transition age youth. Family recovery from the impact of a substance use disorder encompasses five dimensions:

- improvement of personal health and functioning of each family member,
- improvement in the quality of subsystem relationships (adult intimate relationships, parent child relationships, sibling relationships),
- increased clarity and consistency of family roles, rules, and rituals,
- enhanced quality and flexibility of external boundary transactions (the family's relationship with outside kinship and social networks), and
- reduction of risk for intergenerational transmission of AOD addiction and related problems.[46]

Addiction as a Family Disorder: Prolonged and excessive AOD use by a family member can impair family functioning and the personal development and global (physical, emotional, relational) health of individual family members.[47] The adverse effects of childhood exposure to parental addiction may be worse in families that remain intact than in families in which the child is abandoned by the alcoholic parent.[48] Children may also be negatively affected by exposure to sibling substance use, e.g., increased risk of early substance experimentation and subsequent problem development.[49] Same-generation family members (siblings, cousins) can constitute a risk for substance use or a protection against substance use based on their substance-related attitudes and behaviors.[50] This risk can be ameliorated by involving siblings in the treatment of their brother or sister.[51]

Childhood Risk and Resilience: Most children and adolescents rebound from the effects of an adverse childhood environment. Most (60-75%) children of alcohol-

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[46] White, W., & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly*, *23*(4), 3-37; 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**.**

[47] Beardslee, W.R., Son, L., & Vaillant, G.E. (1986). Exposure to parental alcoholism during childhood and outcome in adulthood: A prospective longitudinal study. *British Journal of Psychiatry*, *149*, 584-591. Steinglass, P. (1993). *The alcoholic family*. Hutchinson Education.

[48] McCord, J. (1990). Long term perspectives on parental absence. In L.N. Robins, & M. Rutter (Eds.), *Long term perspective on parental absence* (pp. 116-134). Cambridge: Cambridge University Press.

[49] For a brief review see: Bamberg, J.H., Toumbourou, J.W., & Marks, B. (2008). Including siblings of youth substance abusers in a parent-focused intervention: Pilot test of the Best Plus Program. *Journal of Psychoactive Drugs*, *40*(3), 281-291.

[50] Waller, M.A., Okamoto, S.K., Miles, B.W., & Hurdle, D.E. (2003). Resiliency factors related to substance use/resistance: Perceptions of Native adolescents in the Southwest. *Journal of Sociology and Social Welfare*, *30*, 79-94. Brook, J.S., Whiteman, M., Gordon, A.S., & Brook, D.W. (1988). The role of older brothers in younger brothers' drug use viewed in the context of parent and peer influences. *Journal of Genetic Psychology*, *137*, 133-142.

[51] Bamberg, J.H., Toumbourou, J.W., & Marks, B. (2008). Including siblings of youth substance abusers in a parent-focused intervention: Pilot test of the Best Plus Program. *Journal of Psychoactive Drugs*, *40*(3), 281-291.

dependent parents will not go on to develop AOD problems,[52] but children who have experienced sustained exposure to severe parental addiction and/or mental illness can suffer profound developmental effects and are in greatest need of indicated prevention and early intervention services.[53]

- There is a clear but complex relationship between parental addiction, neglect, and maltreatment of children and the subsequent emotional and behavioral health of children.[54]
- Children, particularly male children, of alcohol/drug-dependent parents are at increased risk of developing these same problems as well as other developmental problems.[55]
- Children of alcohol dependent parents have 4-10 times the risk of experiencing an alcohol use disorder in their lifetimes compared to children without these genetic/environmental risk factors.[56]
- The mechanisms driving risk for intergenerational transmission of AOD problems include biological/genetic vulnerabilities, parental modeling, child/family distress, inadequate conveyance of coping skills, positive alcohol expectancies (particularly for males), and increased environmental availability of AOD.[57]

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[52] Beardslee, W.R., Son, L., & Vaillant, G.E. (1986). Exposure to parental alcoholism during childhood and outcome in adulthood: A prospective longitudinal study. *British Journal of Psychiatry, 149*, 584-591. Pandina, R.J., & Johnson, V. (1989). Familial drinking history as a predictor of alcohol and drug consumption among adolescent children. *Journal of Studies on Alcohol, 50*, 245-254.

[53] Werner, E.E. (2004). Journeys from childhood to midlife: Risk, resiliency and recovery. *Pediatrics, 114*(2), 492.

[54] Blau, G.M., Whewell, M.C., Gullotta, T.P., & Bloom, M. (1994). The prevention and treatment of child abuse in households of substance abusers: A research demonstration progress report. *Child Welfare, 73*(1), 83-94. White, W., Woll, P., & Webber, R. (2003) *Project SAFE: Best Practices Resource Manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse.

[55] Bennett, L.A., Wolin, S.J., Reiss, D., & Teitelbaum, M.A. (1987). Couples at risk for transmission of alcoholism: protective influences. *Family Process, 26*, 111-129. Goodwin, D.W. (1988). *Is alcoholism hereditary?* New York: Ballantine Books. Merikangas, K.R., Stolar, M., Stevens, D.E., Goulet, J., Preisig, M., Fenton, B., Zhang, H., O'Malley, S., & Rounsaville, B.J., (1998). Familial transmission of substance use disorders. *Archives of General Psychiatry, 55*, 973-979. Russell, M. (1990). Prevalence of alcoholism among children of alcoholics. In M. Windle, & J.S. Searles (Eds). *Children of alcoholics: Critical perspectives* (pp. 9-38), New York: Guildford Press. Schuckit. M.A. (2009). An overview of genetic influences in alcoholism. *Journal of Substance Abuse Treatment, 36*(Suppl), S5-S-14.

[56] Enoch, M. (2006). Genetic and environmental influences on the development of alcoholism. *Annals of the New York Academy of Science, 1094*, 193-201. Goodwin, D.W. (1988). *Is alcoholism hereditary?* New York: Ballantine Books. Russell, M. (1990). Prevalence of alcoholism among children of alcoholics. In M. Windle, & J.S. Searles (Eds). *Children of alcoholics: Critical perspectives* (pp. 9-38), New York: Guildford Press. Sher, K.J. (1993). Children of alcoholics and the intergenerational transmission of alcoholism: A biopsychosocial perspective. In J.S.. Baer, G.A. Marlatt, & R.J. McMahon (Eds), *Addictive behavior across the life span* (p. 3-33), Newbury Park: Sage Publications. Vitaro, F., Dobkin, P.L., Carbonneau, R. & Tremblay, R.E. (1996). Personal and familial characteristics of resilient sons of alcoholics. *Addiction*, 91(8), 1161-1177.

[57] Handley, E., & Chassin, L. (2009). Intergenerational transmission of alcohol expectancies in a high-risk sample. *Addictive Behaviors, 70*, 675-682.

- Children of alcohol/drug dependent parents are also at risk for "indirect recurrence" via a process of "assortative mating" through which they select intimate partners who have or are likely to develop AOD problems.[58]

Parental Recovery and Child Development: Key aspects of family life disrupted by addiction continue to be disrupted during the early years of recovery.[59] For example, child maltreatment by an addicted parent recedes in tandem with recovery initiation, but development or re-establishment of a healthy parent-child relationship can be a prolonged process.[60] Recovery initiation, by suddenly destabilizing family roles, rules, rituals, and relationships, exerts strain on family members and the family system as a whole. Such strain can result in emotional/behavioral problems in children, pose threats to adult intimate relationships, and threaten family stability.[61] Support provided to a family through the transition from active addiction to stable recovery can enhance the development and emotional health of children in the family.[62] Family- and couples-focused treatment generates improved child adjustment outcomes superior to those found in treatments that focus solely on the individual with the substance use disorder.[63]

"Alcohol abuse has pervasive [negative] effects on spouses and children, but these effects diminish or even disappear entirely when the alcoholic family member is recovering."[64] Multiple studies confirm the improved health of the children of a substance-dependent parent who enters and sustains a recovery process.[65] The chain of

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[58] Bennett, L.A., Wolin, S.J., Reiss, D., & Teitelbaum, M.A. (1987). Couples at risk for transmission of alcoholism: protective influences. *Family Process*, *26*, 111-129. Grant, J.D., Heath, A.C., Bucholz, K.K., & Madden, P.A. (2007). Spousal concordance for alcohol dependence : Evidence for assortative mating or spousal interaction effects? *Alcoholism: Clinical and Experimental Research, 31*(5), 717-728. Hall, R.L, Hesselbrock, V.M., & Stabenau, J.R. (1983). Familial distribution of alcohol use: II. Assortative mating of alcoholic probands, *Behavior Genetics, 13*(4), 373-382. Olmsted, M.E., Crowell, J.A., & Waters, E (2003). Assortative mating among adult children of alcoholics and alcoholics. *Family Relations, 52*(1), 64-71.

[59] Brown, S. (1994). What is the family recovery process? *The Addiction Letter, 10*(10), 1, 4. Brown, S., & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model*. New York & London: Guilford Press.

[60] White, W., Woll, P., & Webber, R. (2003) *Project SAFE: Best Practices Resource Manual*. Chicago, IL: Illinois Department of Human Service, Office of Alcoholism and Substance Abuse.

[61] Brown, S., & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model*. New York & London: Guilford Press.

[62] Brown, S. (1994). What is the family recovery process? *The Addiction Letter, 10*(10), 1, 4. Brown, S., & Lewis, V. (1999). *The alcoholic family in recovery: A developmental model*. New York & London: Guilford Press.

[63] Powers, M.B., Vedel, E., & Emmelkamp, P.M.G. (2008). Behavioral couples therapy (BCT) for alcohol and drug use disorders: A meta-analysis. *Clinical Psychology Review, 28*(6), 952-962.

[64] Moos, R.H., Finney, J.W. & Cronkite, R.C (1990). *Alcoholism Treatment: Context, process and outcome.* Oxford University Press; O'Farrell, T.J., & Feehan, M. (1999). Alcoholism treatment and the family: Do family and individual treatments for alcoholic adults have preventative effects for children. *Journal of Studies on Alcohol, Supplement 13*, 125-129.

[65] Burdzovic, A.J, O'Farrell, T. J., & Fals-Stewart, W. (2006). Does individual treatment for alcoholic fathers benefit their children? A longitudinal assessment. *Journal of Consulting and Clinical Psychology, 74*, 191–198; Callan, V.J., & Jackson, D. (1986). Children of alcoholic fathers and recovered fathers: Personal and family functioning. *Journal of Studies on Alcohol, 47*, 180-182. Kelley, M.L., & Fals-Stewart, W. (2002). Couples- versus individual-based therapy for alcohol and drug abuse: Effects on children's psychosocial functioning. *Journal of Consulting and Clinical Psychology, 70*, 417-427. Moos,

influence behind such improvement seems to be professional treatment, which increases AA or other mutual aid attendance, which enhances abstinence rates, which in turn generate improvements in the behavioral health of the children of those treated.[66] These effects are present even when children are not directly involved in family/child-oriented treatment processes.

There are a growing number of interventions designed to enhance protective/resiliency factors in children exposed to AOD problems within their families that could be integrated into mainstream addiction treatment.[67] Some treatment programs, such as the Betty Ford Center, have invested considerable resources in developing a child-focused service and support track for the children of parents treated at the Center.

There is a rapidly accumulating body of scientific evidence that addiction and recovery each exert a profound influence on the family in general and on children in particular. In spite of this evidence, services provided by the mainstream addiction treatment system for those affected by severe AOD problems range from non-existent, to "reactive, poorly thought out and marginal,"[68] to exemplary models that have yet to be widely replicated. It remains to be seen whether defining the roles of family and children within recovery-oriented systems of care will alter this bleak appraisal.

Recovery of Adolescents and Transition Age Youth

Discussing recovery in the context of adolescent and young adult substance use disorders rests on several critical points.

Problem Prevalence and Help-Seeking: In 2007, 317,279 adolescents (under the age of 18) and 330,581 transition age youth (18-24) were admitted for specialized addiction treatment in the United States.[69] 7.9% of youth aged 12-17 met diagnostic criteria for a substance use (alcohol or illicit drugs) disorder, but less than one tenth (7.6%) of those youth received specialized addiction treatment in the past year.[70] More than one fifth (21.1%) of transition age youth (aged 18-25) met diagnostic criteria for a substance use (alcohol or illicit drugs) disorder, but less than one tenth (7%) received specialized addiction treatment in the past year.[71] The profile of transition age youth most

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R.H., & Billings, A.G. (1982). Children of alcoholics during the recovery process: Alcoholics and matched control families. *Addictive Behaviors, 7*, 155-163.

[66] Burdzovic Andreas, J.B., & O'Farrell, T.J. (2009). Alcoholics Anonymous attendance following 12-step treatment participation as a link between alcohol-dependent fathers' treatment involvement and their children's externalizing behaviors. *Journal of Substance Abuse Treatment, 36*, 87-100.

[67] Finkelstein, N., Rechberger, E., Russell, L.A., VanDeMark, N.R., Noether, C.D., O'Keefe, M., Gould, K., Mockus, S., & Rael, M.V. (2005). Building resilience in children of mothers who have co-occurring disorders and histories of violence. *The Journal of Behavioral Health Services and Research*. *32*(2), 141-154.

[68] Copella. A., & Orford, J. (2002). Addiction and the family: Is it time for services to take notice of the evidence. *Addiction*, *97*, 1361-1363.

[69] SAMHSA/OAS 2009, Personal communication with Dr. James Collier.

[70] SAMHSA/OAS 2009 Personal communication with Dr. James Collier.

[71] Substance Abuse and Mental Health Services Administration, Office of Applied Studies (June 25, 2009). *The NSDUH Report: Young adults' need for and receipt of alcohol and illicit drug use treatment, 2007*. Rockville, MD: Author.

in need of treatment is that of a young adult male with a family income of less than $20,000 or more than $75,000 who does not perceive himself as needing treatment.[72]

Specialized Resources for Adolescent Treatment and Recovery: Treatment and recovery support resources for adolescents have grown explosively in the past three decades.[73] The SAMHSA-sponsored 2000 National Survey of Substance Abuse Treatment Services[74] provided a window into the rapidly growing network of adolescent treatment programs in the United States. Of the 13,428 addiction treatment programs that participated in the survey, 4,969 provided services to adolescents. Adolescent treatment services were provided by 37% of private non-profit facilities, 36% of private for-profit facilities, 34% of state-operated facilities, and 65% of tribal owned facilities.[75]

There is also a growing network of young peoples' recovery support meetings and internet-based social networking/support sites for youth[76] as well as newly developed, assertive procedures aimed at enhancing linkage, engagement, and ongoing participation in such groups.[77]

Adolescent Treatment and Recovery Outcomes: A recent review[78] of adolescent treatment outcome research drew several important conclusions, including the following:

1. Many adolescents mature out of substance-related problems in the transition into adult role responsibilities; for other adolescents, substance-related problems evolve into a chronic, debilitating disorder.
2. Adolescents who mature out of substance-related problems often do so without conceptualizing these problems and their resolution within an addiction/recovery framework.
3. Factors that increase risk and inhibit maturing out include a family history of AOD problems, early age of initiation of regular use, co-occurring emotional/behavioral problems, and a low level of positive family and peer support.
4. The earlier the intervention (in terms of both age and months/years of use), the better the long-term recovery outcomes.
5. There are evidence-based, brief therapies that are effective for many substance-involved adolescents.
6. Viewed as a whole, the most common outcomes of adolescent treatment are enhancements in global functioning (increased emotional health and improved

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[72] Substance Abuse and Mental Health Services Administration, Office of Applied Studies (June 25, 2009). *The NSDUH Report: Young adults' need for and receipt of alcohol and illicit drug use treatment, 2007*. Rockville, MD: Author.

[73] White, W., Dennis, M., & Tims, F. (2002). Adolescent treatment: Its history and current renaissance. *Counselor, 3*(2), 20-23.

[74] Office of Applied Studies (OAS) (2000). *Substance Abuse and Mehtanl Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS), October, 2000*.

[75] Office of Applied Studies (OAS) (2000). Substance Abuse and Mehtanl Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS), October, 2000.

[76] Passetti, L., & White, W. (2008). Recovery meetings for youth. *Journal of Groups in Addiction and Recovery, 2*, 97-121.

[77] 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.

[78] Risberg, R., & White, W. (2003) Adolescent substance abuse treatment: Expectations versus outcomes. *Student Assistance Journal, 15*(2), 16-20.

functioning in the family, school, and community) and reduced substance use (to approximately 50% of pre-treatment levels) rather than complete and enduring cessation of alcohol and other drug use.

7. All treatment programs are not the same: programs with the best clinical outcomes: a) treat a larger number of adolescents, b) have a larger budget, c) use evidence-based therapies, d) offer specialized educational, vocational, and psychiatric services, e) employ counselors with two or more years experience working with adolescents, f) offer a larger menu of youth-specific services (e.g., art therapy, recreational services), and g) are perceived by clients as empathic allies in the long-term recovery process.
8. Most adolescents are precariously balanced between recovery and relapse in the months following addiction treatment.[79] The period of greatest vulnerability for relapse is in the first 30 days following treatment; adolescents' status at 90 days following treatment is highly predictive of their status at one year following treatment.
9. Recovery stability is enhanced by post-treatment monitoring and periodic recovery checkups.[80]
10. The adolescent's post-treatment peer adjustment is a major determinant of treatment outcome. Adolescents who experience major relapse have the highest density of substance users in their post-treatment social milieu.
11. The post-treatment home environment also plays a significant role in recovery/relapse outcomes.
12. Recovery mutual aid networks (AA, NA, etc.) can offer considerable support for long-term recovery, but they suffer from low teen participation rates, and their effect is dependent upon intensity and duration of participation.

The Phenomenology of Adolescent Recovery: The concept of recovery seems to be a viable one for adolescents seeking to reconstruct their lives following significant and sustained AOD-related problems.[81]

Conceptual Frameworks for Organizing Child and Adolescent Services

There are multiple concepts that have served or could serve as an organizing framework for the design of child and adolescent (C & A) services.

System of Care: The concept of "system of care" has provided an organizing framework for the modern reform of children's mental health services.[82] System of care

[79] Godley, S.H., Dennis, M.L., Godley, M.D., & Funk, R.R. (1999). Thirty-month relapse trajectory cluster groups among adolescent discharged from out-patient treatment. *Addiction*, *99*(Suppl 2), 129-139.

[80] 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. 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.

[81] Long, W., & Vaughn, C. (1999). "I've had too much done to my hear"" The dilemma of addiction and recovery as seen through seven youngsters' lives. *Journal of Drug Education*, *29*(4), 309-322.

values and principles grew out of the recognition that the prevailing model of mental health care for children suffered serious problems related to attraction and accessibility, restrictiveness, and isolation from other youth and family services. There was also concern that prevailing models of care suffered from paternalism (failure to involve youth in decisions related to their own care), family exclusion (blame rather than invitation for service participation), and a lack of understanding about cultural differences across youth and families being served. What emerged was a vision of a youth/family-focused, comprehensive, coordinated, and community-based "system of care" for children and families needing mental health care and new planning frameworks (e.g., "wraparound" approaches) to create such a system of care.[83]

In April 2003, the CSAT Strengthening Communities for Youth Performance Monitoring Work Group identified nine "system of care" principles that should be applied to the design of treatment for adolescent substance use disorders. The Work Group concluded that such care should be:

- family and youth focused,
- culturally competent,
- partnership (interagency/intra-agency) guided,
- coordinated/collaborative,
- community-based,
- accessible/no wrong door,
- individualized,
- clinically competent, and
- accountable.[84]

Positive youth development (PYD) is a strategy for developing personal (physical, emotional, cognitive, social, and moral) competence in all children and adolescents.[85]

> *When using the PYD approach, workers focus on youth assets rather than deficits, collaborate with youth in planning the youth's future, build youth competencies rather than doing tasks for the youth, adopt a holistic perspective of healthy personal growth, and engage in long-range planning rather than short-term solutions*.[86]

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[82] Stroul, B., & Friedman, R. (1996). The system of care concept and philosophy. In B. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society* (pp. 1-22). Baltimore, MD: Paul H. Brookes Publishing Co., Inc.

[83] Stroul, B. (2002). *Issue brief—System of care: A framework for system reform in children's mental health*. Washington D.C.: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

[84] Modified from CMHS system of care principles on April 3-4, 2003

[85] Amodeo, M., & Collins, M.E. (2007). Using a positive youth development approach in addressing problem-oriented youth behavior. *Families in Society: Journal of Contemporary Social Services*, *88*(1), 75-85.

[86] Amodeo, M., & Collins, M.E. (2007). Using a positive youth development approach in addressing problem-oriented youth behavior. *Families in Society: Journal of Contemporary Social Services*, *88*(1), 75-85.

PYD is asset-based, collaborative, community-oriented, competence-building, connected (relationship focused), culturally nuanced, holistic, long-range, normative (emphasis on shared similarities with other youth), promotive (focused on pro-social activity), and universal (aimed at all youth).[87] While PYD shares much in common with the resiliency and recovery concepts, PYD is distinguished from resilience and recovery by the PYD focus on the entire universe of children and adolescents rather than just those at high risk or who are already experiencing problems.

Resilience "is the ability of individuals to remain healthy even in the presence of risk factors."[88] It can be thought of as protective shields existing at multiple levels of the ecosystem or as relational processes across these levels that bestow varying levels of immunity in the face of risk exposure.

Definitions of resilience widely differ. Some define resilience as a protective shield of traits that neutralize risk factors to yield a state of *invulnerability* or *extreme hardiness.* Others define resilience as the ability to rebound from toxic influences and traumatic experience. Some of the latter definitions use resilience and recovery interchangeably or link the two conditions.

There is growing consensus that resilience exists only in the context of adversity. Resilience is not a euphemism for health/wellness, social competence, or academic/vocational functioning—conditions often achieved in the absence of adversity. Resilience instead refers specifically to positive developmental outcomes in spite of personal and environmental risk factors.[89] Whereas the focus of PYD is on all children, resilience applies to the ability of risk-exposed children and adolescents to avoid developing problems related to those risk factors. Resilience does not apply to all children, only those exposed to risk. Put simply, without risk, there is no resilience.[90]

Resilience has been an important concept in the context of child services because it helped the field move from a "discourse of psychopathology and failure" to a discourse of potential.[91] Resilience is a valuable term applied to developmental problems of children and adolescents because it affirms a naturally positive momentum for human development. The fact is, most children experiencing childhood distress will not experience prolonged effects from such distress or will have recovered from such problems when re-evaluated at mid-life.[92] The resilience concept also brings a clear identification of risk and protective factors, optimism related to long-term developmental outcomes in spite of personal adversity, and the importance of high expectations, care

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[87] Amodeo, M., & Collins, M.E. (2007). Using a positive youth development approach in addressing problem-oriented youth behavior. *Families in Society: Journal of Contemporary Social Services*, *88*(1), 75-85.

[88] *Risk and resilience 101* (2004). National Center for Mental Health Promotion and Youth Violence Prevention. Retrieved July 30, 2009 from http://www.promoteprevent.org.

[89] Rutter, M. (2006). Implications of resilience concepts for scientific understanding. *Annals of New York Academy of Science, 1094*, 1-12.

[90] Meschke, L.L., & Patterson, J.M. (2003). Resilience as a theoretical basis for substance abuse prevention. *Journal of Primary Prevention, 23*, 483-514. Ungar, M. (2005). A thicker description of resilience. *The International Journal of Narrative Therapy and Community Work, 3/4*, 89-96.

[91] Ungar, M. (2005). A thicker description of resilience. *The International Journal of Narrative Therapy and Community Work, 3/4*, 89-96.

[92] Werner, E.E. (2004). Journeys from childhood to midlife: Risk, resiliency and recovery. *Pediatrics*, *114*(2), 492.

and support, and meaningful participation within service organizations and the larger life of the community.[93]

The research on protective factors is particularly important for the design of children's services. Studies of children at risk for the development of AOD problems who did not develop such problems reveal a variety of protective shields. Theokas and Lerner[94] have conceptualized these shields in terms of personal assets (social conscience, personal values, interpersonal values and skills, risk avoidance, activity participation, positive identity, and school engagement) and ecological assets (connection to family, adult mentors, connection to community, parent involvement, connection to school, rules and boundaries, and safety) that can enhance resiliency and positive development of youth.

Trait-based protective factors include:

- cognitive skills (intelligence, attention, problem solving),[95]
- "easy temperament, a low level of emotional reactivity, and a normal level of novelty-seeking,"[96]
- social orientation (desire for and capacity to enjoy social interaction), sociability, and sustained social relationships,
- self-confidence and optimism about one's future,[97]
- pro-social values and beliefs, and
- spiritual/religious orientation.[98]

The family environment can also include protective factors that reduce risk of AOD problem development in children of an alcohol-dependent parent. These factors include:

- positive relationship with the non-alcoholic parent,[99]
- close supervision of children by the non-alcoholic parent,[100]
- quality relationship with both parents,[101]

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[93] Bernard, B. (2004). *Resilience: What we have learned*. San Francisco, WestEd.

[94] Theokas, C., & Lerner, R.M. (2005). Developmental assets and the promotion of positive development: Findings from Search Institute Data. *Focal Point: Research, Policy and Practice in Children's Mental Health, 19*(1), 27-30.

[95] Luthar, S.S. (2003). *Resilience and vulnerability: Adaptation in the context of childhood adversities.* New York: Plenum.

[96] *Resilient children of parents affected by a dependency* (2004). (Originally published as Comité Permanet de Lutte á la toxicomanie)

[97] *Resilient children of parents affected by a dependency* (2004). (Originally published as Comité Permanet de Lutte á la toxicomanie)

[98] Langehough, S.O., Walterns, C., Knox, D., & Rowley, M. (1997). *Spirituality & Religiosity as factors in adolescents' risk for anti-social behaviors and use of resilient behaviors.* Paper presented at the annual Conference of the NCFR Fatherhood and Motherhood in a Diverse and Changing World Conference, Arlington, VA.

[99] Reich, W., Earls, F., Frankel, O., & Powell, J.J. (1988). A comparison of the home and social environments of children and alcoholic and non-alcoholic parents. *British Journal of Addiction, 83,* 831-839.

[100] Vitaro, F., Dobkin, P.L., & Zoccolillo, M. (1996). Personal and familial characteristics of resilient sons of male alcoholics. *Addiction, 91,* 1161-1177.

- maintenance of key family rituals, e.g., family celebrations (birthdays, holidays), family traditions (vacations, reunions), and patterned routines (meals, bedtimes),[102] and
- access to social support outside the family.[103]

Finally, there are community protective factors that reduce the risk of developing AOD-related problems. Luthar[104] lists four such factors:

- access to quality education,
- participation in social/athletic activities supervised by adults,
- safe and cohesive neighborhoods, and
- access to health and social services.

Mershke and Patterson[105] reviewed the research on protective factors and drew the following conclusions:

- Protective factors are not static; they advance, are maintained, or recede as each layer of the ecosystem evolves.
- Protective factors are most important during windows of vulnerability, e.g., transition from childhood to adolescence.
- Protective factors are to resilience what recovery capital is to the long-term resolution of AOD problems.
- Protective factors increase in potency and duration of effects when combined.

Resistance has two potential meanings relevant to the current discussion: 1) an innate hardiness that allows one to be exposed to an infectious agent without becoming ill, and 2) the act of desisting or ceasing AOD use as an act of cultural or political survival.[106] The former views resistance as synonymous with resilience; the latter views abstinence as an act of personal and cultural survival in response to the perceived use of alcohol and other drugs as tools of social oppression or as a toxic balm used to ease the pain of such oppression. Resistance in this latter view is seen as critical to the process of personal, cultural, and political awakening of historically disempowered peoples. In such contexts, healing the individual, family, and community are viewed as inseparable and

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[101] Kuntsche, E., Van Der Vorst, H., & Engels, R. (2009). The earlier the more? Differences in the links between age at first drink and adolescent alcohol use and related problems according to quality of parent-child relationship. *Journal of Study of Alcohol and Drugs, 70,* 346-354.

[102] Bennett, L.A., Wolin, S.J., & Reiss (1988). Cognitive behavioral and emotional problems among school-age children of alcoholic parents. *American Journal of Psychiatry, 145,* 185-190. Wolin, S.J., Bennet, L.A., Noonan, D.L., & Teitelbaum, M.A. (1980). Disrupted family rituals: A factor in the intergenerational transmission of alcoholism. *Journal of Studies on Alcohol, 41,* 199-214.

[103] *Resilient children of parents affected by a dependency* (2004). (Originally published as Comité Permanet de Lutte á la toxicomanie)

[104] Luthar, S.S. (2003). *Resilience and vulnerability: Adaptation in the context of childhood adversities.* New York: Plenum.

[105] Meschke, L.L., & Patterson, J.M. (2003). Resilience as a theoretical basis for substance abuse prevention. *Journal of Primary Prevention, 23,* 483-514.

[106] Dan D. (2008). *Resilience thinking and recovery management: Notes toward an ecological model of system transformation*. Unpublished Manuscript. Coyhis, D., & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery-The truth about the lie*. Colorado Springs, CO: White Bison, Inc.

require action at all of those levels.[107] Whereas resilience emphasizes latent strengths and capacities, resistance emphasizes the importance of individual and collective *consciousness* and *action.* The concept of resistance has particular salience within historically disempowered communities.[108]

Recovery from a substance use disorder has been recently defined in terms of three critical ingredients: sobriety, global health (physical, cognitive, emotional, relational, spiritual), and citizenship.[109] The term *recovery* as traditionally used applies only to those with a pre-existing disorder (there must be something to recover from) and those who meet key criteria of personal volition and durability (recovery must be voluntary and extended—measured across time via categories of early, sustained, and stable recovery). Pathways (secular, spiritual, religious) and personal styles of recovery initiation and maintenance vary considerably across individuals and cultures.[110] The concepts of *family recovery* and *community recovery* have also been applied to families and communities who repair and transcend the adverse systemic effects of severe and prolonged AOD problems.[111]

What has not been fully explored is the application of the recovery concept to youth. Because the recovery concept was developed out of a base of adult experience, its meanings and utility become less clear as one moves its application from transition age youth to adolescents to children. Even the basic dimensions of recovery must be defined in the context of youth development. For example,

- Do adolescents transitioning into adulthood who resolve severe AOD problems by decelerating AOD use to subclinical levels rather than stopping AOD use meet the "sobriety" definition of recovery? How would a "recovery-oriented" model of care view such patterns of problem resolution?
- How does the measurement of global health differ for youth than for adults? How can key developmental tasks of childhood, adolescence, and transitioning into adulthood be integrated in the "global health" component of recovery?
- How does the concept of citizenship apply to children and adolescents? What behaviors would distinguish the achievement of this dimension of recovery for children and adolescents?

Such questions have yet to be fully answered.

Recovery Management and Recovery-Oriented Systems of Care

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[107] *The Red Road to Wellbriety* (2002). Colorado Springs, CO: White Bison, Inc.

[108] White, W., & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, *26*(3), 365-395.

[109] 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. Laudet, A.B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment*, *33*, 221-228. White, W. (2007) Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229-241.

[110] White, W., & Kurtz, E. (2006). The varieties of recovery experience. International Journal of Self Help and Self Care, *3*(1-2), 21-61. White, W., & Sanders, M. (2008). Recovery management and people of color: Redesigning addiction treatment for historically disempowered communities. *Alcoholism Treatment Quarterly*, *26*(3), 365-395.

[111] White, W.L. (2007). A recovery revolution in Philadelphia. *Counselor*, *8*(5), 34-38.

Recovery management is a philosophy of organizing addiction treatment and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery.[112] *Recovery-oriented systems of care* (ROSC) encompass the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families affected by AOD problems and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes. The "system" in this phrase is not a federal, state, or local agency, but a macro level organization of the larger cultural and community environment in which long-term recovery is nested.[113] *Systems transformation* involves planned efforts to align service concepts, service practices, and service contexts (e.g., community attitudes, funding, and regulatory policies) to support long-term addiction recovery for individuals, families, neighborhoods, and communities. ROSC rest on key principles or understandings about recovery (See Table 3) and contain key defining characteristics (See Table 4).

Table 3: Recovery-Oriented Systems of Care: Guiding Principles

1. There are many pathways to recovery.
2. Recovery is self-directed and empowering.
3. Recovery involves a personal recognition of the need for change and transformation.
4. Recovery is holistic.
5. Recovery has cultural dimensions.
6. Recovery exists on a continuum of improved health and wellness.
7. Recovery emerges from hope and gratitude.
8. Recovery involves a process of healing and self-definition.
9. Recovery involves addressing discrimination and transcending shame and stigma.
10. Recovery is supported by peers and allies.
11. Recovery involves (re)joining and (re)building a life in the community.
12. Recovery is a reality.

Source: CSAT National Summit on Recovery, September 28-29, 2007[114]

Table 4: Characteristics of a Recovery-Oriented System of Care

1. Person-centered
2. Family and other ally involvement

[112] 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.

[113] White, Ibid.

[114] Center for Substance Abuse Treatment. (2007). *National Summit on Recovery: Conference Report* (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration.

3. Individualized and comprehensive services across the lifespan
4. Systems anchored in the community
5. Continuity of care
6. Partnership-consultant relationships
7. Strength-based
8. Culturally responsive
9. Responsiveness to personal belief systems
10. Commitment to peer recovery support services
11. Inclusion of the voices and experiences of recovering individuals and their families
12. Integrated services
13. System-wide education and training
14. Ongoing monitoring and outreach
15. Outcomes driven
16. Research-based
17. Adequately and flexibly financed

Source: CSAT National Summit on Recovery, September 28-29, 2007[115]

CSAT's 2007 National Summit on Recovery was followed by a 2008 "Consultative Session to Design a Recovery-Oriented System of Care for Adolescents and Transition Age Youth with Substance Use Disorders or Co-Occurring Mental Health Disorders." Table 5 summarizes how participants of this meeting defined the critical characteristics of an ROSC for youth.

Table 5: Characteristics of a Recovery-Oriented System of Care for Youth

1. Family-focused/family driven
2. Age appropriate/developmental approach
3. Promotes resilience
4. Empowers youth
5. Acknowledges non-linear nature of recovery
6. Strengths-based
7. Addresses recovery capital
8. Individualized
9. Promotes hope
10. Broad array of services and supports
11. Culturally competent
12. Accessible
13. Provides choices
14. Promotes personal responsibility
15. Integrated
16. Ecological/systems perspective
17. Continuity of care
18. Engaging

[115] Center for Substance Abuse Treatment. (2007). *National Summit on Recovery: Conference Report* (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration.

19. Non-discriminatory
20. Collaborative
21. Cost-effective
22. Authenticity (honesty, integrity, fun, respect, trust, tolerance, patience)
23. Evidence-based
24. Focuses on quality of life
25. Flexible
26. Promotes accountability (outcomes)
27. Realistic
28. Statewide-level of organization

Source: Cavanaugh, Goldman, Le, & Bender, 2008[116]

Three things are striking in the comparison of Tables 3 and 4 with Table 5. First, the definition of core elements of an ROSC for adults and youth share many if not most common elements, e.g., emphasis on individualized care, family involvement, personal/family strengths, continuity of care, cultural competence, and accountability of outcomes. Second, stakeholders who defined the ideal ROSC for youth placed greater emphasis on developmentally appropriate services, resilience, empowerment/choice, and access/engagement. Third, in spite of the general call for more developmentally appropriate services in Table 5 and in the larger literature on the application of ROSC to youth, there is a striking lack of detail about what this means. There is not a clear delineation of the role of peer-based recovery support services within a youth-focused ROSC nor guidance on how to maintain peer supports over time (via peer leadership development initiatives) and how to avoid any potential iatrogenic effects of peer-based interventions. Also lacking is a clear definition of the meaning of family-focused youth services, e.g., how the developmental task of emancipation from family can be balanced with the need for sustained family support for recovery, or how concepts like empowerment and choice will be applied to children and adolescents. There is much work to be done to define a youth-focused ROSC at the level of service practice design.

Shared Characteristics of Organizing Concepts

Whereas the concepts of system of care and positive youth development were developed specifically to address concerns related to services for children and adolescents, resilience and recovery have historically been drawn from adult experience and then applied, often without adaptation, to children and adolescents. In spite of their varied pedigrees, there is considerable overlap between all of these concepts. For example, the key elements of system of care and positive youth development have much

[116] Cavanaugh. D., Goldman, S., Le, L., & Bender, C. (2008b). *Consultative session to design a recovery-oriented system of care for adolescents and transition age youth with substance use disorders or co-occurring mental health disorders*. CSAT/CMHS/SAMHSA Recovery Consultative Meeting, November 13-14, 2008.

in common with the key elements being defined as crucial to a recovery-oriented system of care.[117]

While resilience and recovery are often thought of as separate phenomenon, at least some investigators have suggested that recovery may actually be a manifestation of resilience that occurs after exposure to the adversity of addiction. This suggests the need to define resilience with a life-span trajectory and to consider the possibility that recovery may be a manifestation of a delayed form of resilience activated by some developmental turning point.[118] Resilience (in the face of extremely adverse experience) and recovery similarly share overlapping strategies: achieving both states involves identity reconstruction (who was I, what happened, who am I now—or who am I becoming), assertive approaches to emotional self-management, and forging a healthy social support network.[119]

Those who have studied recovery and resilience refer to a level of extraordinary functioning that can emerge not in spite of past risk factors but because of one's experience of having transcended such risks. White and Kurtz[120] refer to an "enriched state of recovery"—a depth of meaning and purpose, a level of functioning, and a style of service to others far superior to their pre-addiction state. Such amplified recovery occurs as an unexpected fruit of recovery for some individuals/families. This finding parallels Calhoun and Tedeschi's[121] findings that some individuals experience profoundly positive changes in the aftermath of traumatic distress. These changes include an expanded vision of life opportunities, deepening of intimate and social relationships, strengthening of personal character and coping abilities, a refocusing of priorities, and heightened experience of spirituality.[122] Rutter[123] has also explored the "steeling effect" in which experiencing adversity at one stage of life strengthens resistance to such distress at another level of life—a phenomenon suggested by the phrase "stronger at the broken places." This is analogous to people achieving heightened immunity following exposure to an infectious agent.

Rather than think of recovery and resilience in either/or terms, it may be helpful to think of systems transformation guided by both resilience and recovery. Child and family advocates in many places have embraced these concepts as complementary.[124] Figure 1 illustrates how these concepts might be viewed as linked with a total system of care and support.

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[117] Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal*, *31*(1), 38-48.

[118] Rutter, M. (2006). Implications of resilience concepts for scientific understanding. *Annals of New York Academy of Science*, *1094*, 1-12.

[119] Millar. G.M., & Stermac, L. (2000). Substance abuse and child maltreatment: Conceptualizing the recovery process. *Journal of Substance Abuse Treatment, 19*(2), 175-182.

[120] White, W., & Kurtz, E. (2006). The varieties of recovery experience. International Journal of Self Help and Self Care, *3*(1-2), 21-61.

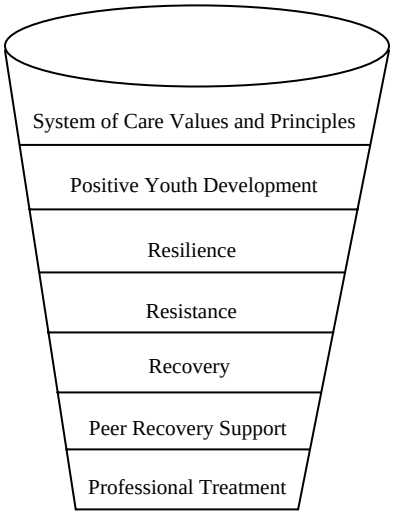
[121] Calhoun, L.G., & Tedeschi, R.G.. Eds. (2006). *Handbook of post-traumatic growth: Research and practice*. Mahwah, NJ: Erlbaum.

[122] Neimeyer, R.A. Ed. (2001). *Meaning reconstruction and the experience of loss.* Washington D.C.: American Psychological Association.

[123] Rutter, M (1981) Maternal Deprivation Reassessed, Second edition, Harmondsworth, Penguin.

[124] Walker, J.S., & Garner, T. (2005). Resilience *and* recovery: Changing perspectives and policy in Ohio. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 25-26.

Figure 1: Organizing Concepts for AOD-Related Services for Children and Adolescents



Whichever concepts are embraced, the field of children's services appears committed to casting aside pathologizing concepts and language that focus attention on "disorder and disease" and embracing new concepts and language focused on "hoping and coping."[125] The field also appears poised to reject models that define problems, resilience, and recovery as exclusively intrapersonal processes. The future lies in a focus on the ecology of resilience and recovery—placing these experiences and service strategies derived from them in their family, community, and cultural contexts.[126]

Primary Prevention, Early Intervention, Treatment, and Recovery Support

Discussions of the applicability of the recovery and resiliency concepts to children's services lead to questions about where prevention and early intervention fit into an ROSC. Prevention programs can be divided into universal approaches (targeting the general population), selective approaches (targeting groups at high risk for subsequent

[125] Ungar, M. (2005). A thicker description of resilience. *The International Journal of Narrative Therapy and Community Work, 3/4*, 89-96.

[126] Waller, M.A., Okamoto, S.K., Miles, B.W., & Hurdle, D.E. (2003). Resiliency factors related to substance use/resistance: Perceptions of Native adolescents in the Southwest. *Journal of Sociology and Social Welfare, 30*, 79-94.

AOD problems), and indicated approaches targeting individuals already exhibiting the emotional/behavioral precursors associated with later AOD problems.[127] Given that 1) children of parents with a history of substance use disorders are among those at highest risk for developing such disorders, 2) the recovery of the parent increases the child's resistance to and potential recovery from a substance use disorder, and 3) at risk children of parents in treatment can be identified and targeted for prevention and early intervention strategies, there is a clear link between addiction treatment and recovery support for the parent and strategies of prevention and early intervention with their at risk or substance-using children. Put simply, addiction treatment and recovery support services for parents constitute a strategy of prevention for their children. These strategies can be further amplified by involving children in the treatment of their parent and by providing specialized services designed to enhance the child's recovery from the developmental insults of parental addiction and to enhance the child's future resilience and resistance related to AOD-related problems.

The pool of people currently experiencing substance use disorders is not static, but a dynamic ever-changing population. Entry into this pool progressively draws from five groups:

1. individuals in recovery from AOD problems who remain at risk for returning to AOD use and its concomitant problems,
2. AOD consumers who are experiencing subclinical problems (not yet meeting diagnostic criteria for a substance use disorder) related to their AOD use,
3. heavy consumers of AOD as measured by frequency and quantity of use,
4. episodic and moderate but at risk AOD consumers, and
5. children, adolescents, and adults who have not yet used AOD but who are at high risk for the development of AOD problems.

Recovery-oriented systems of care must respond not just to those in acute crisis and those who need recovery maintenance support. The ideal ROSC seeks to shrink the size of all of the above populations via effective strategies of prevention and early intervention. ROSC, with its larger focus on promoting recovery-friendly communities, actually elevates the value and importance of such strategies. As an example, one could easily take the position based on the data presented in this paper that the treatment of every adult parent should include child-focused prevention and early intervention services aimed at breaking the intergenerational transmission of AOD-related problems.

Recovery Concept and Children: Advocates

Several major arguments have been set forth advocating the "added value" the recovery concept brings to service design efforts for children, adolescents, and transition age youth. These proposed advantages include the following:

[127] Gordon, R. (1987). An operation classification of disease prevention. In J.A. Steinberg, & M.M. Silberman (Eds.), *Preventing mental disorders: A research perspective* (DHHS Pub. No. (ADM) 87-1492). Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute of Mental Health.

- Recovery as an organizing concept helps shift attention from diagnosis and clinical treatment of children toward a more holistic, developmental perspective.[128]
- Recovery helps shift the focus of children's services from that of pathology, deficit inventories, and doomed prognoses to a focus on hope/optimism for each child's long-term positive development and the achievement of a meaningful and purposeful life.[129]
- Recovery adds the needed dimensions of wellness (wholeness) and spirituality—the idea that there are previously hidden powers within and outside the self that can be mobilized to promote healing, wellness, and quality of life.[130]
- Recovery emphasizes the importance of empowerment and choice.[131]
- Recovery adds new emphasis on the power of personal identity as an agent of prevention and healing: story construction/reconstruction, storytelling, and story listening.[132]
- Recovery contains the potential to move beyond symptom reduction to the potential to thrive: transcending illness/trauma in ways that render one a better person and bestow a fuller and more meaningful life than existed before,[133] e.g., recovery offering new competencies, unexpected opportunities, deeper

[128] Theokas, C., & Lerner, R.M. (2005). Developmental assets and the promotion of positive development: Findings from Search Institute Data. *Focal Point: Research, Policy and Practice in Children's Mental Health, 19*(1), 27-30.

[129] Friesen, B.J. (2005). The concept of recovery: "value added" for the children's mental health field? *Focal Point: Research, Policy and Practices in Children's Mental Health, 19*(1), 5-8. Oswald, D.P. (2006). Recovery and child mental health services. *Journal of Child and Family Studies, 15*, 525-527. Walker, J.S., & Freisen, B.J. (2005). Resilience and recovery: Findings from the Kauai longitudinal study. *Focal Point: Research, Policy and Practice in Children's Mental Health, 19*(1), 3-4. White, W.L., Laudet, A.B., & Becker, J.B. (2006). Life meaning and purpose in addiction recovery. *Addiction Professional, 4*(4), 18-23.

[130] Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal, 31*(1), 9-22.

[131] Langehough, S.O., Walterns, C., Knox, D., & Rowley, M. (1997). *Spirituality and Religiosity as factors in adolescents' risk for anti-social behaviors and use of resilient behaviors.* Paper presented at the annual Conference of the NCFR Fatherhood and Motherhood in a Diverse and Changing World Conference, Arlington, VA. Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal, 31*(1), 9-22; 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

[132] Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal, 31*(1), 9-22; White, W. (1996). *Pathways from the Culture of Addiction to the Culture of Recovery*. Center City, MN: Hazelden.

[133] Onken, S.J., Craig, C.M., Ridgway, P., Ralph, R., & Cook, J. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal, 31*(1), 9-22. White, W., & Kurtz, E. (2006). The varieties of recovery experience. *International Journal of Self Help and Self Care, 3*(1-2), 21-61.

relationships, greater compassion, reordered personal priorities, and deepened spirituality.[134]

- The recovery concept is very congruent with the *positive youth development* (PYD) movement and "system of care" values and principles that have guided the design of child services since the 1980s.[135]
- The idea of "parallel process" within the ROSC literature acknowledges systems failures within the professional treatment of adolescent substance use and mental health disorders and the need for a recovery process for systems of care as well as individuals and families.[136]
- Recovery as an organizing concept brings needed elements not traditionally included in child and adolescent services, e.g., understandings of historical trauma and social stigma and the emphasis on treating/healing the environment.[137]
- The recovery management model promises needed continuity of support over time to the child/family and offers an alternative to the sense of abandonment that often accompanies acute care models of adolescent intervention,[138] but care must be taken not to indiscriminately apply a "chronic care" model to adolescents—many of whom will experience acute, transient AOD problems. Such misapplication could have significant iatrogenic (harm in the name of help) effects.[139]
- Integrating the ideas of recovery and resilience "draws attention to the importance of connectedness as a developmental asset for all youth."[140]
- Using recovery as an organizing concept for children's services provides impetus for the involvement of primary care physicians in the assessment and early intervention into child and adolescent AOD problems.[141]
- The focus on the role contextual factors play in the development and resolution of adolescent substance use disorders (e.g, the influence of AOD availability, AOD peer group norms, AOD-related laws and institutional

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[134] Walsh, F. (2007). Traumatic loss and major disasters: Strengthening family and community resilience. *Family Process*, *46*(2), 207-227.

[135] Eccles, J.S., & Gootman, J.A. (Eds.) (2002). *Community programs to promote youth development*. Washington D.C.: National Academy Press. Huffine, C. (2005). Supporting recovery for older children and adolescents. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 22-23.

[136] Lamb, R., Evans, A.C., & White, W. (2009) *The role of pPartnership in recovery-oriented systems of care: The Philadelphia experience.* Unpublished Manuscript. Oswald, D.P. (2006). Recovery and child mental health services. *Journal of Child and Family Studies, 15*, 525-527.

[137] Friesen, B.J. (2005). The concept of recovery: "value added" for the children's mental health field? *Focal Point: Research, Policy and Practices in Children's Mental Health*, *19*(1), 5-8.

[138] 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.

[139] White, W., Boyle, M., & Loveland, D. (2003). Addiction as chronic disease: From rhetoric to clinical application. *Alcoholism Treatment Quarterly, 20*, 107-130.

[140] Walker, J.S., & Freisen, B.J. (2005). Resilience and recovery: Findings from the Kauai longitudinal study. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 3-4.

[141] Knight, J.R. (2001). The role of primary care provider in preventing and treating alcohol problems in adolescence. *Ambulatory Pediatrics*, *1*(3), 150-161.

policies, alcohol advertising, etc.) may sharpen our examination of how these same factors influence adult AOD problems and their resolution.[142]

Recovery Concept and Children: Critics

The major arguments against applying the recovery concept to children, adolescent, and transition age youth services include the following:

- The recovery concept (and other "re" words—*reform*, *redeem*, *rebirth*, *regeneration*, *rehabilitation*—applied to the resolution of severe and prolonged AOD problems) implies return to a previous state of health and functioning rather than the forward developmental trajectory through childhood and adolescence into adulthood; recovery is an adult concept misapplied to children.[143] (Youth-focused recovery models counter this by incorporating the concept of *discovery* into their recovery concept and reinterpreting the meaning of recovery across the life cycle.)
- The term *recovery* is not well understood by stakeholder groups within the child and adolescent service arena; some like the idea of recovery (its hope and optimism), but do not like the word.[144] This is an example of how stigma could lead to the rejection of recovery as an organizing concept.
- The recovery concept fails to "draw attention to some of the issues that are particularly important for children and families."[145]
- The term *recovery* implies a medicalized disease orientation that lacks the developmental perspective critical to children's services.[146]
- The recovery concept, with its focus on the resolution of a particular illness or problem, inhibits a more holistic understanding of the child/family's assets, needs, and aspirations.[147]

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[142] Hawkins, J.D., Catalano, R.F., & Miller, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin*, *112*, 64-105.

[143] Theokas, C., & Lerner, R.M. (2005). Developmental assets and the promotion of positive development: Findings from Search Institute Data. *Focal Point: Research, Policy and Practice in Children's Mental Health, 19*(1), 27-30. Walker, J.S. & Garner, T. (2005). Resilience *and* recovery: Changing perspectives and policy in Ohio. *Focal Point: Research, Policy and Practice in Children's Mental Health, 19*(1), 25-26.

[144] Walker, J.S., & Freisen, B.J. (2005). Resilience and recovery: Findings from the Kauai longitudinal study. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 3-4.

[145] Walker, J.S. & Garner, T. (2005). Resilience *and* recovery: Changing perspectives and policy in Ohio. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 25-26.

[146] Friesen, B.J. (2005). The concept of recovery: "value added" for the children's mental health field? *Focal Point: Research, Policy and Practices in Children's Mental Health*, *19*(1), 5-8. Theokas, C., & Lerner, R.M. (2005). Developmental assets and the promotion of positive development: Findings from Search Institute Data. *Focal Point: Research, Policy and Practice in Children's Mental Health, 19*(1), 27-30. Walker, J.S. & Garner, T. (2005). Resilience *and* recovery: Changing perspectives and policy in Ohio. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 25-26.

[147] Theokas, C., & Lerner, R.M. (2005). Developmental assets and the promotion of positive development: Findings from Search Institute Data. *Focal Point: Research, Policy and Practice in Children's Mental Health, 19*(1), 27-30.

- Recovery—with its reversal of illness focus—is not appropriate as a conceptual framework for organizing services for young children, but may offer some advantages in the organization of services for adolescents.[148]
- Much of what is called for in recovery-focused systems transformation efforts has already been emphasized in "system of care" models of children's services, e.g., "comprehensive, coordinated, community-based, individualized, culturally competent, child centered and family focused."[149]
- The recovery model's emphasis on self-determination, empowerment, choice, and personal responsibility is inappropriate at worst and at best, difficult to apply to children.[150]
- Many aspects of the recovery concept and recovery-related service practices must be significantly adapted to fit the developmental stages of the adolescent and the developmental stages of adolescent recovery.[151]
- The term *recovery* may set unrealistic and universal expectations of "full cure" for children with severe behavioral health problems.[152] Conveying expectations of "full cure" may also be inappropriate within systems of care that also provide services for children and adolescents with severe developmental disabilities.
- The term *recovery* carries social stigma attached to addiction that should not be indiscriminately applied to children's services.[153] The term *recovery* has been rejected in other arenas in favor of *resilience* on the grounds that recovery carries "negative surplus meaning"—a professional euphemism for the stigma attached to severe substance use and other psychiatric disorders.[154]
- The term *recovery* brings added value but is not inclusive enough; combining these concepts via the phrase *resilience and recovery* best captures the conceptual elements critical to the needed transformation in children's mental health services.[155]

Debate over the application of recovery to the C & A service arena is handicapped by recovery advocates who are not knowledgeable about prevailing concepts in the C &

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[148] Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal*, *31*(1), 38-48.

[149] Friesen, B.J. (2005). The concept of recovery: "value added" for the children's mental health field? *Focal Point: Research, Policy and Practices in Children's Mental Health*, *19*(1), 5-8.

[150] Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal*, *31*(1), 38-48.

[151] Blumberg, D. (2004). Stage model of recovery for chemically dependent adolescents: Part 1—methods and models. *Journal of Psychoactive Drugs*, *36*(3), 323-345. Blumberg, D. (2005). Stage model of recovery for chemically dependent adolescents: Part 2—Model evaluation and treatment implications. *Journal of Psychoactive Drugs*, *37*(1), 15-25.

[152] Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal*, *31*(1), 38-48.

[153] Oswald, D.P. (2006). Recovery and child mental health services. *Journal of Child and Family Studies*, *15*, 525-527.

[154] Sandler, I.N., Wolchik, S.A., & Ayers, T.S. (2008). Resilience rather than recovery: A contextual framework on adaptation following bereavement. *Death Studies*, *32*, 59-73.

[155] Walker, J.S. & Garner, T. (2005). Resilience *and* recovery: Changing perspectives and policy in Ohio. *Focal Point: Research, Policy and Practice in Children's Mental Health*, *19*(1), 25-26.

A service arena and child advocates who are unfamiliar with the efforts to nuance the recovery concept within a developmental perspective. Debates over ideas and language from both sides may mask issues of personal, professional, and organizational status and power. Put simply, these discussions can sometimes tap very primitive interests and emotions.

The Philadelphia Focus Groups

The Philadelphia Department of Behavioral Health and Mental Retardation Services conducted a series of focus groups during the summer of 2008 to discuss several basic questions related to the application of the concept of recovery to children and adolescent services and to define core characteristics of an ROSC for children and adolescents. Separate focus groups were hosted for service providers, parents, family members, and representatives from the Youth Leadership Council.

Focus group participants expressed support for blending the concepts of resilience and recovery as an organizing framework for youth services, with the caveat that communicating the definitions of and relationship between these two terms throughout the behavioral health care system would enhance clarity of service planning and the quality of service practices. Common domains of activity/focus were defined that were shared by both the recovery and resiliency concepts and that needed definition and refinement in the context of children's services. These domains included:

- developmentally-informed models of care,
- family inclusion/direction and leadership,
- peer support and leadership,
- continuum of support (versus continuum of care), e.g., support that includes but transcends professional treatment and embraces prevention activities,
- community integration and mobilization of community recovery/resiliency support resources,
- trauma-informed care (and addressing violence within the trauma framework), and
- culturally competent care.

One of the priorities expressed in the focus groups was the need for models and mechanisms of family partnership/leadership and family-focused programming. Potential strategies discussed included:

- youth advisory boards/family advisory councils,
- family representation on policy boards,
- development of grassroots family advocacy organizations,
- new strategies of family assessment and engagement,
- formal family orientation/education programs,
- use of family advocates by treatment organizations,
- family-inclusive treatment,
- family support groups,
- family-focused alumni activities,
- parenting education groups/classes,

- development of clinical and family peer recovery support service options for family members (children and siblings in particular) of all persons admitted for addiction treatment, and
- development of new family peer support programs.

A group of youth much discussed in the Philadelphia focus groups was transition age youth who were "aging out" of the child service system with little transitional support when they were no longer eligible to continue receiving services. It was hoped that new approaches to such transition planning could be developed given the ROSC emphasis on long-term, stage-appropriate recovery support.

The Voices of Youth

Before outlining recommendations based on this review, we thought it appropriate to give the final words of input of the 16 youth who participated in recent focus groups in Philadelphia. Here were some of the sentiments expressed by those young people.

Understand me, don't force things on me, don't have pre-judgments/assumptions based on what you read about me. Learn to know me and take a fresh approach.

Don't use the chart except to know the worst thing I am capable of.

Try to get to know me. Connect with me on a personal level. Get to understand my point of view. Ask me relaxed questions, don't drill me. Ask me "what is going on in your life right now?"

Don't have my family involved unless it is okay with me.

List the positive stuff about me that you see; that helps me to open up. Look for the talents I have as a person, sometimes you might figure it out before me. Build a base with me (of relationship), I can tell a lot about you from your face, from your tone of voice.

Tell me something about yourself. If I know anything about you beyond what degrees you have, it helps me to open up. But don't tell me too much about yourself. I had a therapist who told me all her troubles, that wasn't why I was there.

Don't use words I don't understand…I am already scared, make me feel safe.

Be a human being I can connect with; don't use stuff out of books.

Don't blow things out of proportion, just because I make a mistake doesn't mean I am oppositional or sick, it just means I made a mistake.

Don't diagnose me without cause just because I have to have a diagnosis to get funding, and don't medicate things that can be talked out.

A peer counselor would help because you can't trust school counselors. Except for one who helped set up a peer group at school with kids who were going through the same thing as me. That helped me a lot.

There is so much violence in the community it isn't safe to be connected there.

I disagree. I think we need to be connected to good things that are going on in the community.

You go where you get respect and feel powerful, and that may be a gang in the community.

I had nowhere to go, nothing to do but then someone sent me to the PAL center. There were activities there and adults (mostly cops) to relate to. Therapists need to know these resources.

Summary and Recommendations

So what are the "take home" messages from this sweeping discussion of the use of recovery as an organizing concept for children and adolescent services and the role of such services within efforts to transform addiction treatment and the larger communities in which treatment is imbedded into recovery-oriented systems of care? Several points seem critical:

- A recovery-focused transformation in behavioral healthcare is underway in the United States and other countries, but the implications of such transformation processes on child and adolescent (C & A) services have not been fully defined.
- Recovery offers "added value" as an organizing concept for C & A services, but its greatest potential within the C & A service arena lies in its integration with the concepts of resilience and resistance.
- Recovery as an organizing concept has multiple applications to the C & A service arena:
    1. the achievement of sobriety, global health, and citizenship by children, adolescents, and transition age youth experiencing a substance use disorder,
    2. reversing the developmental insults experienced by children and adolescents who have been exposed to the addiction of a parent or sibling, and
    3. reducing the risks of intergenerational transmission of AOD problems.
- The concept of recovery has particular utility within the C & A services arena in light of the lowered age of onset of AOD use and the increased prevalence of adolescent substance use disorders.

- Treatment resources for adolescent substance use disorders have increased dramatically in the United States, but brief biopsychosocial stabilization is often followed by resumption of AOD use and its concomitant problems. Efforts are needed to extend acute treatment to sustained, post-treatment recovery support.
- *Recovery management* as a philosophy of treatment has much to offer adolescents and transition age youth with severe and complex AOD problems but could generate iatrogenic effects (harm in the name of help) if indiscriminately applied to all AOD-using youth.
- The emerging conceptualization of the core elements of a *recovery-oriented system of care* (ROSC) for children, adolescents, and transition age youth has much in common with earlier organizing frameworks (e.g., system of care and positive youth development) for children and adolescent services.
- It is crucial that a youth-focused ROSC reflect the full integration of primary prevention, early intervention, clinical treatment, and non-clinical recovery support services.
- Arguments for and against the use of recovery as an organizing construct for C & A services are not mutually exclusive. Strategies should be developed that capitalize on the positive additions recovery brings to C & A services and that minimize untoward effects that the application of this concept could generate within C & A services.
- There is growing consensus that an ROSC for C & A should be designed to:

    1. Assure youth and parent involvement in the planning, design, conduct, and evaluation of prevention, early intervention, treatment, and post-treatment recovery support services.
    2. Instill traits and experiences known to serve as protective factors (competence, confidence, attachment, flexibility, opportunity).
    3. Enhance parenting skills, elevate supervision patterns, and re-establish/strengthen family rituals of adults and their partners being treated for a behavioral health disorder.[156]
    4. Reduce family, neighborhood, and community stressors.
    5. Promote "positive chain reactions"—saturated support, guidance, and multiple opportunities during periods of elevated risk.[157]
    6. Provide access to family counseling and counseling for the children and adolescents of adults undergoing addiction treatment. Sankaran[158] advocated that all addiction treatment programs include programs for families and children that focused on improved parenting and equipping children with specific skills (self-esteem, coping, conflict resolution, and assertiveness) to enhance resilience.

[156] Sankaran, L., Muralidhar, D., & Benegal, V. (2006). *Strengthening resilience with families in addiction treatment.* Unpublished Paper.

[157] Rutter, M. (2005). Natural experiments, casual influences, and policy development. In M. Rutter, & M. Tienda (Eds), *Ethnic variations in intergenerational continuities and discontinuities in psychosocial features and disorders*. New York & London: Cambridge University Press.

[158] Sankaran, L., Muralidhar, D., & Benegal, V. (2006). *Strengthening resilience with families in addiction treatment.* Unpublished Paper.

7. Provide youth-to-youth and parent-to-parent peer-based recovery support services.[159]
8. Assure AOD-involved children and adolescents a continuum of support that spans pre-recovery identification and engagement, recovery initiation and stabilization, recovery maintenance, and enhanced quality of personal/family life in long-term recovery.[160]
9. Provide assertive approaches to continuing support following specialized addiction treatment.[161]
10. Assure transitional supports for youth who are aging out of the child service system.

The following recommendations are offered as points for continued discussion as the City of Philadelphia continues its behavioral health care systems transformation process and seeks to fully involve C & A services within that transformation process.

The Concepts and Language of Systems Transformation

1. Expand the Language of Systems Transformation. The phrase "supporting recovery, building resilience, and enhancing self-determination" ("recovery, resilience, and self-determination" for short) to describe systems transformation efforts offers a means of bridging the three DBH/MRS service arenas (addiction, mental health, and developmental disabilities) and a framework for integrating primary prevention, early intervention, treatment, and non-clinical recovery support services. Discussions of the common and distinguishing features of positive recovery, resilience, resistance, youth development, and systems of care may enhance our capacity to "develop complex, ecologically-based interventions that address the child in the context of family and community."[162]
2. Elevate Asset-Focused Language. Services for children, adolescents, and transition age youth should focus on strengths of individuals, families, and communities. Elevating the concepts of *recovery*, *resiliency*, *protective factors*, and *recovery capital* within DBH/MRS could underscore this emphasis on personal, family, and community assets.
3. Explicitly Define "Youth." Conduct all discussions of youth service needs within a framework that distinguishes the differences in these needs for children, adolescents, and transition age youth.

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[159] *Blamed and ashamed.* (2001). Alexandria, VA: Federation of Families for Children's Mental Health.

[160] 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

[161] 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. 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.

[162] Friesen, B.J. (2007). Recovery and resilience in children's mental health: Views from the field. *Psychiatric Rehabilitation Journal*, *31*(1), 38-48.

Representation and Leadership

1. Model Representation/Leadership within DBH/MRS. Designate positions within the Office of Addiction Services Advisory Board for youth and family representation.
    - Recruit youth and family members for inclusion in key DBH/MRS leadership development activities, e.g., Peer Group Facilitation Training, Recovery Foundations Training, Peer Leadership Academy, and Storytelling Training.
    - Designate leadership positions on Advisory Boards for youth and family representation.
    - Involve youth and family members in planning the redesign of the service system.
    - Facilitate ways for youth and family members to participate in critical evaluation tasks such as conducting focus groups with peers, assisting with the development of satisfaction surveys, etc.
    - Develop separate youth and family advisory councils that have direct access to the leadership within the system.
    - Create expectations for youth and family leadership within provider agencies and align monitoring processes to assess provider compliance.
    - Involve transition age youth and families in the monitoring of services.

2. Encourage Representation/Leadership in Behavioral Health Care Network via dissemination of papers on best practices and provision of technical assistance.

Recovery Visibility of Youth

1. Establish and Monitor Youth Recovery Prevalence. Conduct, evaluate, and publicly disseminate recovery prevalence survey data (household and school surveys) for youth 18 years of age or younger. (Work with existing surveys to assure inclusion of questions that allow reporting of youth recovery prevalence.)
2. Encourage and support a vanguard of recovering young people whose life circumstances allow and who are called to put a face and voice on recovery among young people.

Collaboration and Partnership

1. Work with Mayor's Blue Ribbon Commission on Children's Behavioral Health and the Office of Addiction Services to integrate the concepts of resilience and recovery at planning and service practice levels.

Develop a Continuum of (Personal/Family/Community) Recovery Support

1. Replace the concept of "continuum of care" with "continuum of support" to provide a broader conceptual umbrella to integrate primary prevention, early

intervention, clinical treatment, non-clinical recovery support services, recovery community building activities, and advocacy of policies aimed at enhancing the resilience and recovery of children and adolescents.

2. Explore ways to nest the process of recovery and wellness in young people's natural environments rather than focusing solely on how to get youth with AOD-related problems into treatment. These strategies might include:
    - partnerships with athletic clubs, neighborhood groups, recreation centers, libraries, faith communities, local shopping centers to conduct prevention activities, outreach, early identification/intervention,
    - conducting youth-focused surveys of community recovery capital (Mapping AOD problems indicator data for youth, youth-focused treatment, and recovery support resources by zip code to identify areas of unmet service needs, to evaluate the effects of neighborhood-targeted service projects, and to identify areas in the community that need additional recovery supports), and
    - exploring how indigenous community resources can be used to extend post-treatment support for youth and families from a few weeks or months to the years spanning the transition from adolescence into young adulthood.

3. Support expanded prevention and early intervention strategies, particularly among high risk youth to prevent or postpone use of intoxicants. This would entail:
    - forging partnerships with schools, faith community, etc. to raise awareness and increase community level resources (protective factors/recovery capital) that can enhance the health of at risk and recovering youth, and
    - lowering the threshold of engagement for substance-involved youth, e.g., viewing motivation as a service/support outcome rather than a requirement for service/support initiation and shifting from confrontational to motivational methods of engagement and support.

4. Utilize an expanded continuum of support model with adolescents and transition age youth with severe and complex AOD problems**.** Explore the use of recovery check-ups (post-treatment monitoring and support) and formal systems of peer-based recovery coaching for adolescents with severe and prolonged AOD problems—saturating such support in the first 90 days following primary treatment.[163]

Practice Guidelines

[163] 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. 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.

1. Develop distinct recovery/resiliency-oriented practice guidelines for children/adolescents within all practice guideline documents.
2. Explore development of a wide range of youth-to-youth and parent-to-parent peer recovery support services, including family-to-family outreach.[164]

Assessment and Treatment/Recovery Planning

1. Encourage the use of global screening and assessment procedures that address multiple youth and family life domains, as opposed to problem-specific approaches.
2. Encourage holistic approaches to adolescent care and support, e.g., multidisciplinary and multi-agency intervention models that can provide an integrated response to youth and families experiencing multiple challenges.
3. Encourage the transition from professionally-directed treatment plans to personalized, family- and youth-directed recovery plans.[165]
4. Ensure that treatment services are linked to meaningful goals/desires/activities for each young person.
5. Focus on development of service plans that build competencies in multiple domains (social, emotional, cognitive, etc.) rather than focus only on the remediation of deficits or problem behaviors.

Recovery-Focused Treatment

1. Provide youth and families experiencing AOD-related problems access to evidence-based models of treatment, including family-focused approaches to treatment.
2. Provide family-focused education, professional and peer-based recovery coaching, and continuing care support groups.
3. Provide advocates to help families navigate increasingly complex service systems.
4. Enhance parenting skills, elevate supervision patterns, and re-establish/refine/strengthen family rules and rituals.

Develop a Youth/Family-Focused Peer Recovery Culture

1. Explore the development of a wide range of youth-to-youth and parent-to-parent peer recovery support services, including family-to-family outreach.[166]

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[164] Smith, S.L., Hornberger, S., Brewington-Carr, S. Finck, C., O'Neill, C., Cavanaugh, D., & Bender, C. (2009). Family involvement in adolescents substance abuse treatment. *Improving Access to and Quality of Treatment for Adolescents with Substance Use/Co-Occurring Mental Health Disorders*. *1*(1), 1-7.

[165] Borkman, T. (1998). Is recovery planning any different from treatment planning? *Journal of Substance Abuse Treatment*, *15*(1), 37-42.

[166] Smith, S.L., Hornberger, S., Brewington-Carr, S. Finck, C., O'Neill, C., Cavanaugh, D., & Bender, C. (2009). Family involvement in adolescents substance abuse treatment. *Improving Access to and Quality of Treatment for Adolescents with Substance Use/Co-Occurring Mental Health Disorders*. *1*(1), 1-7.

2. Work with local service committees of recovery mutual aid fellowships to expand the availability of young people's recovery support meetings and persons willing to sponsor young people entering recovery.
3. Utilize assertive linkage procedures between adolescent treatment and local recovery support groups.[167]
4. Explore such peer to peer services as:
    - peer-based adolescent outreach and engagement efforts that are based in natural support settings such as schools, places of worship, community recreation centers, etc.,
    - adolescent and family peer-facilitated support and education groups within treatment settings, particularly within residential treatment facilities,
    - peer-to-peer continuing support services available to youth and families to help sustain the gains made in the treatment context,
    - technology-based peer support strategies that leverage the growing centrality of technology within the daily lifestyle of adolescents, e.g., the use of social networking websites and text messaging for peer support and recovery coaching,
    - adolescents should be engaged in determining what kinds of peer support activities and roles would be helpful in the system, and how these supports might be structured to maximize utilization,
    - web-based peer supports designed to educate and support families, and
    - recruitment and training of younger staff (and young people in recovery) to work with youth.

Evaluate Effects of Systems Transformation on C & A Services

1. Provide a Quality of Care Report Card for the major DBH/MRS-funded C & A service providers.
2. Assure the inclusion of parents and siblings affected by youth substance use disorders and youth in recovery from such disorders in the planning, design, conduct, and evaluation of substance-related services for youth.[168]
3. Conduct a youth-focused survey of community recovery capital. Map AOD problems indicator data for youth-focused treatment and recovery support resources by zip code to identify areas of unmet service needs and to evaluate the effects of neighborhood-targeted service projects.

These recommendations, though grounded in the scientific literature and the growing body of experiential knowledge in the City of Philadelphia, constitute a starting point for continued discussion.

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[167] 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.

[168] Smith, S.L., Hornberger, S., Brewington-Carr, S. Finck, C., O'Neill, C., Cavanaugh, D., & Bender, C. (2009). Family involvement in adolescents substance abuse treatment. *Improving Access to and Quality of Treatment for Adolescents with Substance Use/Co-Occurring Mental Health Disorders. 1*(1), 1-7.

Acknowledgments: Work on this paper was supported by the Great Lakes Addiction Technology Transfer Center/Center for Substance Abuse Treatment/Substance Abuse and Mental Health Services Administration (#5 UD1 T1013593-07), the Philadelphia Department of Behavioral Health and Mental Retardation Services (DBH/MRS), and the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (HHSS2832007006I/TO HHSS28300003T Subcontract No: s8440). The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of DBH/MRS, CSAT, SAMHSA, DHHS, or the Federal Government.

Appendix A: Definitions of Addiction Recovery

Recovery is "overcoming both physical and psychological dependence to a psychoactive drug while making a commitment to sobriety."[169]

"Recovery is the experience of a meaningful, productive life within the limits imposed by a history of addiction to alcohol and/or other drugs. Recovery is both the acceptance and transcendence of limitation."[170]

Recovery is "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles."[171]

Recovery means that someone is "trying to stop using alcohol or drugs."[172]

"The term *Wellbriety* is an affirmation that recovery is more than the removal of alcohol and other drugs from an otherwise unchanged life. Wellbriety is a larger change in personal identity and values and a visible change in one's relationship with others. It is about physical, emotional, spiritual, and relational health. Wellbriety is founded on the recognition that we cannot bring one part of our lives under control while other parts are out of control. It is the beginning of a quest for harmony and wholeness within the self, the family and the tribe."[173]

"Recovery is the process of pursuing a fulfilling and contributing life regardless of the difficulties one has faced. It involves not only the restoration but continued enhancement of a positive identity and personally meaningful connections and roles in one's community. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members."[174]

"Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life."[175]

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[169] ASAM (2001). *Patient placement criteria for the treatment of substance use disorders* (2nd edition). Chevy Chase, MD: American Society of Addiction Medicine.

[170] White, W. (2002). *An addiction recovery glossary: The languages of American communities of recovery*. First posted at www.bhrm.org In White, W. (2006). Let's go make some history: Chronicles of the new addiction recovery advocacy movement. Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

[171] Anthony, W. A., Rogers, E. S., & Farkas, M. (2003). Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal*, *39*(2), 101-114.

[172] Peter D. Hart Research Associates (2004). *Faces and Voices of Recovery Public Survey*. Washington D.C.: Peter D. Hart Research Associates.

[173] *The red road to wellbriety*. (2002). Colorado Springs, CO: White Bison, Inc.

[174] Recovery Advisory Council, Philadelphia Department of Behavioral Health, 2005

[175] Center for Substance Abuse Treatment. (2007). *National Summit on Recovery: Conference Report*. (DHHS Publication No. SMA 07-4276). Rockville, MD: Substance Abuse and Mental Health Services Administration.

"Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship."[176]

"Long-term recovery is an enduring lifestyle marked by: 1) the resolution of alcohol and other drug problems, 2) the progressive achievement of global (physical, emotional, relational) health, and 3) citizenship (life meaning and purpose, self-development, social stability, social contribution, elimination of threats to public safety)."[177]

Appendix B: Definitions of Resilience

Resilience is the "ability of individuals to overcome adversity."[178]

"Resilience refers to a process of adaptation whereby individuals learn to overcome destabilizing effects resulting from traumatic experiences of greater or lesser severity."[179]

"Resilience…manifests itself as successful adaptation at the individual level, despite harmful circumstances or life events normally considered risk factors from the standpoint of adaptation."[180]

"Resilience is the ability of individuals to remain healthy even in the presence of risk factors."[181]

"Resilience is a dynamic process encompassing positive adaptation within the context of significant adversity."[182]

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[176] 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.

[177] 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

[178] Ungar, M. (2005). A thicker description of resilience. *The International Journal of Narrative Therapy and Community Work, 3/4*, 89-96.

[179] Resilient children of parents affected by a dependency (2004) (Originally published as Comité Permanet de Lutte á la toxicomanie).

[180] Resilient children of parents affected by a dependency (2004) (Originally published as Comité Permanet de Lutte á la toxicomanie)

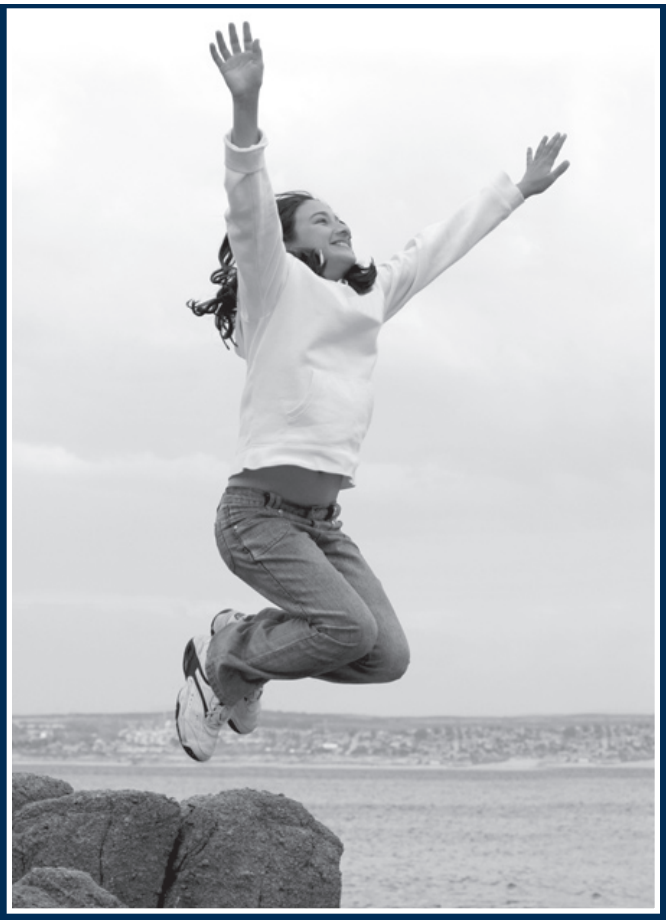
[181] National Center for Mental Health Promotion and Violence Prevention. (2009). *Risk and Resilience 101*. Retrieved April 22 from http://www.promoteprevent.org.

[182] Luthar, S.S., Cichetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71*(3), 543-562.

FOCAL POiNT

Research, Policy, and Practice in Children's Mental Health

Resilience and Recovery



Summer 2005

research & training center portland
ON FAMILY SUPPORT AND CHILDREN'S MENTAL HEALTH

FOCAL POiNT Vol. 19, No. 1

Summer 2005

FOCAL POiNT is a publication of the Research and Training Center on Family Support and Children's Mental Health. This publication was developed with funding from the National Institute on Disability and Rehabilitation Research, United States Department of Education, and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (NIDRR grant H133B040038). The content of this publication does not necessarily reflect the views of the funding agencies.

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WRITE FOR FOCAL POiNT: SOCIAL SUPPORT

We are currently inviting proposals for articles for the Winter 2006 issue of **FOCAL POiNT**, which will focus on the theme of Social Support. What is the role of social support in achieving positive outcomes for children and families? How can social support be measured? Can social support be built around people who lack it?

We invite research reviews, program descriptions, policy discussions, and personal essays. For information about how to propose an article, contact Janet S. Walker, **FOCAL POiNT** editor, at janetw@pdx.edu or 503.725.8236.

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Resilience and Recovery

The final report of the President's New Freedom Commission on Mental Health describes the need for fundamental transformation of mental health care in America. According to the report, successful transformation would result in mental health care that focuses on *facilitating recovery* and *building resilience.* Efforts to transform children's mental health care have been underway for over twenty years; however these efforts have been largely based on the *system of care principles,* which make no direct mention of either recovery or resilience. Understandably, this has led to some confusion about the relationship between a resilience-and-recovery framework on the one hand, and systems of care principles on the other. Are they compatible, or do they represent two distinct visions of transformation?

This issue of *Focal Point* explores the concepts of resilience and recovery and what they mean in the context of mental health care for children and adolescents. From the articles, it emerges that the *terminology* associated with recovery and resilience (particularly the word *recovery* itself) can be confusing and even off-putting to stakeholders in children's mental health. On the other hand, the larger underlying *concepts* of recovery and resilience are appealing to stakeholders, and are also highly compatible with system of care values. This point is explored explicitly in the articles by Barbara Friesen and Charles Huffine, but the same implication appears throughout other contributions as well.

Beyond merely being compatible with system of care values, a resilience-and-recovery perspective highlights new ideas and strategies for transforming mental health care for children and adolescents. For example, Friesen found that young people and their families were most excited by the focus on hope and optimism that figures prominently in both recovery and resilience. Terre Garner similarly reports that young people and families see hope as the cornerstone of effective mental health care. Hal Shorey and C. R. Snyder argue that hope is a crucial element in successful maturation and development, particularly during the transition from childhood to adulthood. What is more, Shorey and Snyder describe a system they have developed for teaching hopeful thinking to adolescents.

Similarly, a resilience-and-recovery framework draws attention to the importance of connectedness as a developmental asset for all youth, including youth who are at-risk, troubled, or struggling with emotional or behavioral difficulties. For younger children, connections to caregivers are central, while for older children and adolescents, other connections become increasingly important: connections to peers and individuals, organizations, and institutions in the wider community. Through these kinds of connections, young people gain emotional support and access opportunities to discover and develop skills, talents, and vision. Young people thrive when their communities are rich in the kinds of opportunities that draw out their assets. This interplay of individual and community assets is explored in detail by Christina Theokis, Richard Lerner, and Erin Phelps, using Search Institute data

from a large and diverse sample of teens.

Hope and connectedness are intertwined in a resilience-and-recovery perspective. Using longitudinal data from her Kauai study, Emmy Werner argues that positive development is promoted when young people acquire the conviction that they can overcome problems by their own actions. This type of hopeful outlook is more likely to develop when young people have emotional support available, and when they have access to opportunities to learn and to acquire skills. In Werner's study, this was true not only for at-risk children who proved resilient, but also for troubled teenagers who recovered as young adults.

On a more personal level, this is the same message delivered by Melanie Green and Angela Nelson. Both young women have developed a hopeful, empowered stance that has enabled them to move ahead in their lives despite considerable adversity. Formal services may help, as they did for Green, or they may contribute to difficulties, as they did for Nelson. Ultimately, however, what these young women seek is a place in the community and the opportunity to develop their skills and talents.

When young people have hope, connectedness, and opportunities, they are more likely to be able to "bounce back" from adversity. A resilience-and-recovery framework helps us expand our thinking about how to provide interpersonal and community environments that help struggling young people acquire these crucial assets and return to a positive developmental path.

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Barbara J. Friesen is Director of the Research and Training Center on Family Support and Children's Mental Health.

Beginning in October 2004, the Research and Training Center on Family Support and Children's Mental Health was funded for five years to undertake six major research projects described below. For more information, visit www.rtc.pdx.edu.

Voices of Youth and Families: Community Integration of Transition-Age Youth is designed to gain understanding of community integration from the perspectives of transition-age youth, young adults, and caregivers, and examine links between the concepts of community integration, youth and family participation in individualized planning, empowerment, the effects of stigma, and recovery and resilience.

Transforming Futures: Research on Expanding the Career Aspirations of Youth with Mental and Emotional Disorders addresses the under-researched area of transition supports and services for youth who are preparing for adulthood, with a specific focus on employment. This project features a web-based intervention connecting youth with adult mentors who have struggled with mental illness and have successful employment outcomes.

Partnerships in Individualized Planning will develop instruments to assess youth empowerment, youth participation in planning, and perceptions of the utility and feasibility of youth participation in planning. The project will also develop and evaluate an intervention to increase the participation of youth and family members in the individualized planning and service process.

Work-Life Integration directly addresses the issue of community integration for the adult caregivers of children and youth with emotional disorders, specifically with regard to their ability to maintain employment. This project is designed to influence the knowledge, attitudes, and practices of human resource professionals, with a view to reducing stigma and increasing the family friendliness of their organizations.

Transforming Transitions to Kindergarten focuses on the families' experiences of the shift from pre-school to kindergarten when children have emotional/behavioral challenges. The project will develop and test a training intervention to increase the capacity of early childhood and kindergarten settings to meet the needs of these children, and a family-driven team-based transition intervention to promote the success of children and their families as they move from pre-school to kindergarten. The project will also include a review of evidence-based practice in the field of mental health consultation.

Practice-Based Evidence: Building Effectiveness from the Ground Up will conduct a case study in partnership with a Native American youth organization and the National Indian Child Welfare Association. The project addresses the need to conduct effectiveness studies of practices that are believed to be helpful, but for which little evidence exists.

Additionally, the Center will continue to undertake a range of dissemination, training, and technical assistance activities. These include our *Building on Family Strengths Conference*, **FOCAL POiNT**, our award-winning website, and our two listservs, *Data Trends* and *rtcUpdates*.

The Concept of Recovery: "Value Added" for the Children's Mental Health Field?

What can the concept of *recovery* add to system of care principles and the emphasis on promoting resilience already operating in the children's mental health field? One answer to this question is "an increased focus on hope, optimism, and a positive orientation to the future." These features of the concept of recovery have been identified as "value added" by many youth, family members, and service providers in the children's mental health field. Others, however, are uncomfortable using *recovery* with children and youth, expressing their belief that the term is confusing, that it implies a medical-illness orientation to mental health treatment, and that it lacks a developmental perspective. Both groups agree that the concept of recovery, as developed within the adult mental health field, cannot be imported "as is" into the children's mental health field.

Background

In September 2004, staff here at the RTC on Family Support and Children's Mental Health were asked to address the question, "What can the concept of recovery add to current thinking and practice in the field of children's mental health?" This information was requested by the Child, Adolescent, and Family Branch, which is part of the Center for Mental Health Services (CMHS), which, in turn, is part of the Substance Abuse and Mental Heath Administration (SAMHSA), the primary federal funder of programs to improve mental health care nationwide.

This interest in recovery was motivated in large part by the 2003 report of the President's New Freedom Commission on Mental Health, which recommended fundamentally transforming how mental health care is delivered in America. According to the report, "Recovery is the goal of a transformed system." The report also states that, "Care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience…"

Federal agencies, including SAMHSA, have been asked to align their work with the recommendations of the New Freedom report. In the field of children's mental health, we are accustomed to talking about resilience; however, not much attention had previously been paid to the question of how recovery might apply to children and youth. RTC staff thus set out to help SAMHSA answer two related questions: first, What exactly does recovery mean in the context of children's mental health? and second, How do recovery and resilience mesh with the system of care values that underpin current transformation efforts for children's mental health?

During the fall and winter 2004-05, we sought feedback on these questions through a series of telephone and in-person discussions with families and youth, as well as with service providers, researchers, and state and local agency administrators. Additionally, in December 2004, we hosted a two-day meeting at SAMHSA sponsored by the Child, Adolescent, and Family Branch, during which representatives from these same stakeholder groups and SAMHSA staff held extended discussions on this topic.

Discussions began with an introduction of the values associated with the recovery concept. We asked participants to consider whether these values, along with lessons from the resilience field, would add new ideas or dimensions for transformation in children's mental health. Some participants suggested that *recovery* should apply only to adults, and *resilience* should be reserved for children. We thought it was important to fully explore what both concepts could offer children's mental health.

Definitions and History

We approached the complex process of thinking about how system of care values and principles, recovery concepts, and resilience knowledge might fit together by looking first at the definitions and main elements of each set of ideas. We developed a "crosswalk" table as a way of looking at where the ideas were similar, and where they were unique (Table 1).

Table 1. Crosswalk: System of Care, Resiliency, and Recovery

Resilience Core Concepts	SOC Principles	Recovery Elements
	1. Comprehensiveness	Holistic (C)
Specification of elements: (V) Reducing risk Enhancing protective factors	2. Individualized services	Individualized and person centered (C) Strengths-based (C)
	3. Community based	(Assumed)
Racial socialization (V) Healing historical trauma (V)	4. Culturally and linguistically competent	Healing historical trauma (V)
Solid basic and applied research base for prevention and early intervention (V)	5. Early intervention	
	6. Family and youth participation Family driven Youth guided, directed	Empowerment Self direction (C)
	7. Service coordination	
	8. Interagency coordination	
	9. Protection of rights	Respect, stigma reduction (V)
	10. Support for transition	Life planning (V)
Future orientation (V) Optimism (V)		Hope, optimism (V)

System of care. A system of care is "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children [with emotional and behavioral disorders] and their families." The system of care values and principles (Stroul & Friedman, 1986) specify that the care provided should be comprehensive, coordinated, community-based, individualized, culturally competent, child centered, and family focused.

Recovery. As defined in the New Freedom report, recovery is "The process in which people are able to live, work, learn, and participate fully in their communities." For some, recovery may mean the complete remission of symptoms. For others, it may mean the ability to live a fulfilling and productive life despite the challenges of an ongoing condition. The concept of recovery was developed in the adult mental health field to describe a process whereby people with serious mental illnesses build fulfilling, self-directed lives in the community. These ideas developed as it became apparent that the life stories of people with positive outcomes contradicted the prevailing pessimistic view of serious mental illness as resulting in inevitable decline over time (Houghton, 1982; Harding, et al., 1987).

Resilience. Concepts of resilience (literally, the ability to "bounce back") have been developed through years of research examining how some individuals do well in many areas of their lives despite severe challenges and/or deprivations (Luthar, Cicchetti, & Becker, 2000). Researchers have identified individual, family, and community characteristics that are associated with resilience. For **individuals**, these include good intellectual functioning, easy-going disposition, self-efficacy, high self-esteem, talents, and faith. **Within the family**, having a close relationship to a caring parent figure, authoritative parenting (characterized by warmth, structure, and high expectations), socioeconomic advantage, and connections to extended family networks have all been shown to be important. **Outside of the family**, factors associated with resilience include bonds to prosocial adults who can serve as good role models, connections to positive community organizations, and attending effective schools (Masten & Coatsworth, 1998). It's important to note that thinking about resilience has changed from focusing extensively on the characteristics of individuals to include the importance of family, neighborhood, and community factors in promoting resilience (Masten & Coatsworth, 1998).

Compatibility of Ideas and Value Added

The crosswalk in Table I allows us to examine how resilience, recovery, and system of care concepts complement each other, and to identify their unique contributions or *value added*. In the following paragraphs, key concepts related to recovery and resilience are examined along with system of care principles.

1. Comprehensiveness. This system of care principle calls for addressing all of the important life domains of developing children and youth—their physical, emotional, social, and educational needs. The recovery element *holistic* represents a very similar idea, including all aspects of the person's mind, body,

spirit, and community, as well as needs such as housing, employment, education, mental health and health care services, addictions treatment, spirituality, and others. The resilience literature does not directly address the concept of comprehensiveness.

2. Individualized services. The language related to this system of care principle, and two recovery elements, *individualized* and *person-centered*, and *strengths-based*, are very similar. They recognize the unique needs of each individual and the importance of building on their strengths and assets. The resilience literature makes a unique contribution with its emphasis on reducing risk (e.g., poverty, exposure to toxic substances, and neighborhood or family violence) and enhancing protective factors (e.g., through building competence and coping in individuals, promoting excellent parenting, and increasing community assets such as caring adults, prosocial organizations, and opportunities for youth to contribute positively to the community).

3. Community based. The principle that children should live at home and in their communities is implicit in the concept of recovery, often with an emphasis on "non-institutional" living situations and full participation in community life.

4. Culturally competent. This value is aligned with the principle of non-discrimination and responsiveness to cultural differences and special needs. The principle focuses on the knowledge and behavior of individual service providers, as well as the appropriateness of services and the process of service delivery. Both the resilience literature and the recovery movement underscore the importance of trauma that may have preceded the emotional or mental illness as well as the traumatic effects of being ill and of receiving treatment in an imperfect and sometimes oppressive system. In addition, the resilience literature contains many examples of racial socialization, a process that parents use to help their children develop pride in their heritage, and to anticipate and prepare for discrimination and prejudice (Coard, Wallace, Stevenson, & Brotman, 2004). An emphasis on healing historical trauma, as well as building increased competence and targeted coping mechanisms in children of color, constitute *value added* from both resilience and recovery.

5. Early intervention. This principle underlines the importance of dealing proactively with problems or challenges rather than letting them become entrenched and more difficult to address. The concept of early intervention is not explicitly discussed in the recovery literature; however, knowledge about resilience building provides valuable information about strategies that can be used to provide early and effective services. For example, as we understand more about the ways in which poverty increases risk of poor outcomes for children (e.g., increasing parents' stress, interfering with parents' ability to provide stable, predictable caregiving, and so on) we can act to counteract these effects (Yates, Egeland, & Sroufe, 2003).

The aspects of recovery that sparked the most interest and excitement were the hope, optimism, and positive orientation to the future that characterize the recovery process…

6. Full family participation in planning, implementing, and evaluating services is a core system of care principle that is also emphasized in the New Freedom report. The idea of involvement and participation has recently been updated to "family driven and youth guided" to communicate that families should provide leadership in decisions about services, and that youth can be effective self-advocates and managers of their own lives. Recovery concepts of consumer empowerment and self-direction parallel concepts of family-driven and youth-guided services.

7. Service coordination is emphasized in the system of care principles because families with complex needs may need a broker, or guide, to help navigate the complicated system of services in their communities and gain access to needed services. Neither resilience nor recovery principles directly addresses service coordination.

8. Interagency coordination is emphasized as a system of care principle to reduce service fragmentation so that children and families with complex needs can be better served.

9. Protection of rights is included as a system of care principle to directly address problems related to coercion, exclusion from decision-making, and other violations. Key elements of recovery, *respect* and *stigma reduction*, are compatible with system of care values, but have not been sufficiently emphasized in the children's mental health field. Attention to building societal acceptance of difference and helping young people gain self-acceptance are *value added* strategies.

10. Support for transitions, although a principle of systems of care, is an area that young people and families identify as needing further development and support. Neither resilience nor recovery explicitly addresses transition planning as a service, although life transitions are identified as presenting challenges to individuals in the resilience literature.

Other elements of recovery that are not emphasized in system of care principles include the notion that progress may be non-linear

(i.e., that setbacks may occur), the notion of personal responsibility, and a heavy emphasis on peer support and peer-run programs.

The aspects of recovery that sparked the most interest and excitement on the part of young people and their families were the concepts of hope and optimism and a positive orientation to the future that characterize the recovery process. In our discussions, family members and youth recalled their frustration and sorrow when they received pessimistic messages about their futures. They also expressed concerns that services are often narrowly focused (not comprehensive) and take a very short-term view. The prospect of having support for life planning, an emphasis on self-management and personal responsibility, and having quality of life seen as a legitimate outcome are all possible contributions of the recovery movement to children's mental health.

On the other hand, an exclusive focus on *recovery* is problematic for many individuals and organizations. We suggest the use of the phrase, *resilience and recovery*, rather than recovery alone, to describe transformation goals, processes, and funding opportunities. This supports the adaptation of important contributions from both the recovery movement and from knowledge about resilience building, and sidesteps objections and confusion related to the term recovery.

Using a resilience and recovery framework, together with system of care principles, has numerous implications for how the transformation of mental health systems should occur. Those implications include the following:

- The outcomes that are important under a resilience and recovery framework are different from those often measured to evaluate either treatment or system effectiveness. For example, outcomes such as optimism or quality of life are rarely measured. Families and youth should be fully engaged in defining resilience- and recovery-oriented outcomes, both for their own individualized plans and for service systems as a whole.
- Protective factors—including community-level strengths and assets—should receive greater attention in treatment planning. There is a need to expand knowledge about how to create treatment plans that effectively build on strengths and assets.
- Transformation work must also be concerned with reducing community risks (e.g., poverty, neighborhood crime, violence, or biohazards). Although the mental health system cannot tackle these problems alone, collaboration with other systems could do much to bring these issues to public awareness, and to make the conceptual connection between community problems and the physical and mental health of all citizens.
- Stigma reduction deserves increased attention. Youth and family experiences of stigma should be used as a basis for developing strategies to reduce stigma.
- Expanded national and local support should be provided for peer-run, mutual support groups and organizations for youth and families.

Although many of the concepts and principles reviewed here are familiar to the children's mental health field, the value that we found through a review of resilience knowledge and in key elements of recovery suggests that these ideas should have a more central place in our work to transform the mental health system across the life span. The effect, we think, should be to move them out of the background and into the spotlight.

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References

Coard, S., et al. (2004). Towards culturally relevant preventive interventions: The consideration of racial socialization in parent training with African American families. *Journal of Child & Family Studies, 13*, 277-293.

Harding, C. M., et al. (1987). The Vermont longitudinal study of persons with severe mental illness: II. *American Journal of Psychiatry 144*, 727-735.

Houghton, J. F. (1982). First-person account: maintaining mental health in a turbulent world. *Schizophrenia Bulletin 8,* 548-552.

Luthar, S. S., et al. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71*, 543-562.

Masten, A. S., & Coatsworth, J. D. (1998). The development of competence in favorable and unfavorable environments. *American Psychologist, 53*, 205-220.

New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health care in America: Final Report* (DHHS Pub. No. SMA-03-3832). Rockville, MD: Author.

Stroul, B. A., & Friedman, R. M. (1986). *A system of care for severely emotionally disturbed children and youth.* Washington, D.C.: Georgetown University, CASSP Technical Assistance Center.

Yates, T. M., et al. (2003). Rethinking resilience: A developmental process perspective. In S. S. Luthar (ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversities* (pp.243-266). Cambridge, UK: Cambridge University Press.

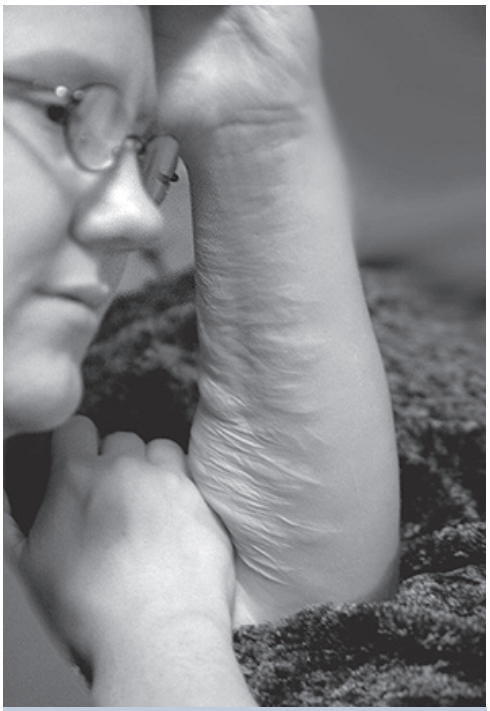
My Path to Recovery

When my alarm goes off on a typical weekday, I reluctantly roll out of bed and jump into the shower. I hurry through breakfast and race off to school. After class, I grab some coffee or a sandwich and then hurry to work. I return phone calls and emails and juggle through the tasks at hand. I stress over prioritizing my responsibilities and figuring out how I will get it all done. When the day is done, I return home to face my homework, put in some time on the treadmill, and eventually collapse into bed.

Sometimes things are pretty overwhelming. I convince myself that there is no way to manage everything that's going on and that I simply can't handle it. But then I stop and think. I think of what I've gone through and what I've achieved. I laugh at myself for stressing so much over work and school. I think of how thankful I am to be working and pursuing my education. And I think about the days when I was simply fighting for my life.

A mere three years ago I lived in a completely different world. I was depressed, anxious, obsessive-compulsive, and mildly psychotic. My emotions were so torturously intense at times that it took all my strength just to live in my own skin. I had no goals and no plans for the future. I wasn't entirely convinced there would even be a future. Self-injury became my primary coping mechanism—as well as my identity.

For several years I was intensely involved with the mental health system. I was hospitalized once per month on average, both in local and state hospitals. I was once described by a psychiatrist as "the number one utilizer of crisis services in the county." With a diagnosis of Borderline Personality Disorder, I was often misjudged by professionals with a lack of understanding of my disorder and of self-injury. I was accused of "just doing it for attention," and told that I was "taking up time and resources that could be used to treat real patients." It was difficult and confusing to be repeatedly put down when I needed help the most.



"An arm full of memories" The scars on Melanie Green's arm remind her not only of what she's been through, but of what she's overcome as well. Photo by Kaarin Peters.

Fortunately, there were people who did understand what I was going through. After meeting with several therapists for various amounts of time, I met one at a local mental health center that I truly connected with. She was trained and experienced in the area of Borderline Personality Disorder and was able to look past my illness and truly appreciate who I was as a person. I slowly gained support and learned new ways to cope with things that were difficult. After long periods of being "drugged-up" on medications like Thorazine, I began to work with an excellent nurse practitioner. Together we found a medication regimen that helped manage my symptoms and, at the same time, permitted me to function. However, even though I was receiving excellent care and support, I continued to struggle. Life was still tumultuous, and I didn't think I could tame it.

It wasn't until an early morning in the emergency room that things started to change. I was in a seclusion room waiting for a psychiatric consultation, having been transferred from a medical bed after overdosing the night before. My stomach ached with regret and I started to cry. "I don't want to do this anymore," I thought. I didn't want to continue living from one cut to the next. I didn't want to spend half my life in hospitals and emergency rooms. I didn't want to *be* my illness anymore.

It took years for my mental illness to develop to such substantial

proportions, and it would take a significant amount of time for me to regain control of my life. But I was finally ready. I was determined to make it happen. Appointments with my therapist changed from being a way to kill some time to being a way to learn new skills. We talked a lot about why I felt the way I did and about the difference between how things sometimes feel emotionally and how they are in reality. I began to understand my emotions, and I gained the power to regulate them rather than be controlled by them. I was fortunate to be working with a therapist who understood and supported me. For every bad feeling I had about myself, she could point out something good. She helped me understand that my life wasn't over. All the skills and attributes I had before my bout with mental illness were still there, there was just other stuff in the way.

I was fortunate to have a mentor as well. By chance, I met a woman who had gone through many of the things I was experiencing. Although her story was different from mine, she recognized enough of what I was going through to convince her to make a commitment to me. She told me she would be there for me and that we'd "get through this together." We spent a lot of time together—sometimes just hanging out, sometimes in serious crisis. The point is, she was there. She still is.

My family also played a significant role in my recovery. My mother relentlessly researched everything connected with my mental illness. Her wealth of acquired knowledge included the details of each diagnosis I received and every medication I took. The rest of my family did everything they could to stand by me and to encourage me to grow strong again. I never understood the value of family until I saw what they all went through for me.

Things didn't get better immediately. It took a lot of time and a lot of hard work. Sometimes I fell back into old patterns. Sometimes I'd give up—but just for a day or two. Every time things got intense, I was able to poke my head out of the chaos just long enough to get a look at the big picture. I started thinking about what I wanted to do with my life and began working on accomplishing it. I started slowly, adding one thing at a time. I went back to school and took one class per quarter. I gradually increased my schedule to two classes, then three. I began volunteering at Consumer Voices Are Born, a local consumer-run agency that provides a drop-in center and "warm line" to adults dealing with mental illness.

As my responsibilities increased, so did my confidence. I began to develop an identity. Rather than a mental illness with a little person inside, I was becoming a person with a little mental illness inside. My efforts were initially slight but quickly gained momentum. Once things started rolling, they never stopped.

In the spring of 2003, I was given the opportunity to help conduct some focus groups in preparation for a new mental health grant that had been awarded to Clark County, Washington. I was flattered by the offer and eager to participate. It never occurred to me that the offer would mark the start of a new beginning. The focus group project led to an invitation to join the steering committee for Clark County's Partnerships for Youth Transition. Later that year I was asked to travel to Washington, D.C. with the program for a cross-site meeting. Within a few months of the trip, I was offered a job as the Youth Coordinator for the program.

Now, with a little over a year of employment with Clark County, I have to take a moment from time to time to reflect on what I've accomplished. Sometimes I still feel like I'm stuck in my old world and that I'll never get out. I remember the way things used to be and wish that I could just erase it all from my life. These are the times when I give myself a pat on the back. I think about the youth I work with and the fact that I'm on the other side now. I think about the people I sit in meetings with—people from the same agencies that used to provide me with services. I think about the numerous presentations I've given at national conferences and the people who come up to me afterwards with compliments and to ask for more information. They're asking *me*—professionals in the mental health field are coming up and asking me for advice. It's amazing. I've been able to take the worst part of my life and turn it into something positive for other people.

I think about the things people tell me and the compliments I receive. They're the same kinds of compliments I received when I was younger, when I knew I was worth something. I went for so long without feeling any value. It is amazing to listen to people and to truly believe that I mean something again. People value me and the contributions I make. I've come back to life.

Recovery is a remarkable thing. For me it has meant gaining my life back. For others it may look different. But it is a possibility for everyone. There is no person alive who can't have things at least just a little bit better—and to me, that's recovery. Recovery is a process. It doesn't necessarily mean that everything will be better and problems will cease to exist. It may mean being able to cook dinner, manage medication, or simply control emotions. It's still important though. Individuals brought down by the weight of mental illness need to be reminded that there is more to their life. They deserve the opportunity to discover who they really are.

Melanie Green is a college student as well as the Youth Coordinator for the Options program in Clark County, Washington, which assists local youth with mental health issues make a successful transition from adolescence to adulthood.

Resilience and Recovery: Findings from the Kauai Longitudinal Study

For many years mental health professionals tended to focus almost exclusively on the negative effects of biological and psychosocial risk factors by reconstructing the life histories of individuals with persistent behavior disorders or serious emotional problems. This retrospective approach created the impression that a poor developmental outcome is inevitable if a child is exposed to trauma, parental mental illness, alcoholism, or chronic family discord, since it examined only the lives of the "casualties," not the lives of the successful "survivors."

During the last two decades of the 20th century, our perspective has begun to change. Longitudinal studies that have followed individuals from infancy to adulthood have consistently shown that even among children exposed to multiple stressors, only a minority develop serious emotional disturbances or persistent behavior problems. Their findings challenge us to consider the phenomenon of *resilience*, a dynamic process that leads to positive adaptation, even with a context of adversity (Luthar, 2003).

Only about a dozen longitudinal studies have examined this phenomenon over extended periods of time—from infancy to adulthood. The Kauai Longitudinal Study is the only study to date that has examined development from birth to midlife. The study explores the impact of a variety of biological and psychosocial risk factors, stressful life events, and protective factors on a multi-racial cohort of 698 children born in 1955 on the Hawaiian island of Kauai, the westernmost county in the U.S.A.

In the Kauai study, a team of mental health workers, pediatricians, public health nurses, and social workers monitored the development of all children born on the island at ages 1, 2, 10, 18, 32, and 40 years. We chose these ages because they represent stages in the life cycle that are critical for the development of trust, autonomy, industry, identity, intimacy, and generativity (Werner & Smith, 1982; 1992; 2001).

Some 30% of the survivors (n=210) in our study population were born and raised in poverty, had experienced pre- or perinatal complications; lived in families troubled by chronic discord, divorce, or parental psychopathology; and were reared by mothers with less than 8 grades of education. Two-thirds of the children who had experienced four or more of such risk factors by age two developed learning or behavior problems by age 10 or had delinquency records and/or mental health problems by age 18.

However, one out of three of these children grew into competent, confident and caring adults. They did not develop any behavior or learning problems during childhood or adolescence. They succeeded in school, managed home and social life well, and set realistic education-

al and vocational goals and expectations for themselves. By the time they reached age 40, not one of these individuals was unemployed, none had been in trouble with the law, and none had to rely on social services. Their divorce rates, mortality rates and rates of chronic health problems were significantly lower at midlife than those of their same sex peers. Their educational and vocational accomplishment were equal to or even exceeded those of children who had grown up in more economically secure and stable home environments. Their very existence challenges the myth that a child who is a member of a so-called "high-risk" group is fated to become one of life's losers.

Resilience in the Formative Years

Three clusters of protective factors differentiated the resilient boys and girls who had successfully overcome the odds from their high-risk peers who developed serious coping problems in childhood or adolescence.

1. Protective factors within the individual. Even in infancy, resilient children displayed temperamental characteristics that elicited positive responses from their caregivers. At age one, their mothers tended to characterize them as active, affectionate, cuddly, good-natured, and easy to deal with; at age two, independent observers described the resilient toddlers as agreeable, cheerful, friendly, responsive, and sociable. They were more advanced in their language and motor development, and in self-help skills than their peers who later developed problems.

By age 10, the children who succeeded against the odds had higher scores on tests of practical problem-solving skills and were better readers than those who developed behavior or learning problems. They also had a special talent that gave them a sense of pride, and they willingly assisted others who needed help. By late adolescence, they had developed a belief in their own effectiveness and a conviction that the problems they confronted could be overcome by their own actions. They had more realistic education and vocational plans, and higher expectations for their future than did their peers with coping problems.

2. Protective factors in the family. Children who succeeded against the odds had the opportunity to establish, early on, a close bond with at least one competent, emotionally stable person who was sensitive to their needs. Much of this nurturing came from substitute caregivers, such as grandparents, older siblings, aunts, and uncles. Resilient children seemed to be especially adept at "recruiting" such surrogate parents.

Resilient boys tended to come from households with structure and rules, where a male served as a model of identification, and where there was encouragement of emotional expressiveness. Resilient girls tended to come from families that combined an emphasis on independence with reliable support from a female caregiver. The families of these children tended to hold religious beliefs that provided some stability and meaning in their lives.

3. Protective factors in the community. Resilient youngsters tended to rely on elders and peers in their community for emotional support and sought them out for counsel in times of crisis. A favorite teacher was often a positive role model, so were caring neighbors, elder mentors, parents of boy- or girlfriends, youth leaders, ministers, and members of church groups.

Recovery in Adulthood

One of the most striking findings in our follow-up studies done in adulthood (at ages 32 and 40) was that most of the youth who had developed serious coping problems in adolescence had staged a recovery by the time they reached midlife. This was true for the majority of the "troubled teens," but more so for the females than the males.

Overall, the "troubled" teenagers had slightly higher mortality rates by age forty (4.4%) than their resilient peers (3.3%) and the "low-risk" members of the same birth cohort (2.8%), with more fatalities due to accidents and AIDS. The majority of the survivors, however, had no serious coping problems by the time they reached midlife. They were in stable marriages and jobs, were satisfied with their relationships with their spouses and children, and were responsible citizens in their community.

Several turning points led to lasting positive shift in the life trajectories among the high-risk men and women in our cohort who had been troubled teenagers. These changes took place after they had left high school and without the benefit of planned intervention by professional "experts." One of the most import lessons we learned from our follow-up in adulthood was that the *opening of opportunities* in the third and fourth decade of life led to enduring positive changes among the majority of teenage mothers, the delinquent boys, and the individuals who had struggled with mental health problems in their teens.

Among the most potent forces for positive change for these youth in adulthood were continuing education at community colleges and adult high schools, educational and vocational skills acquired during service in the armed forces, marriage to a stable partner, conversion to a religion that demanded active participation in a "community of faith," recovery from a life-threatening illness or accident, and, to a much lesser extent, psychotherapy.

Attendance at community colleges and enlistment in the armed forces provided "troubled" teenagers with the opportunity to obtain educational, vocational, and social skills that made it possible for them to move out of welfare dependence

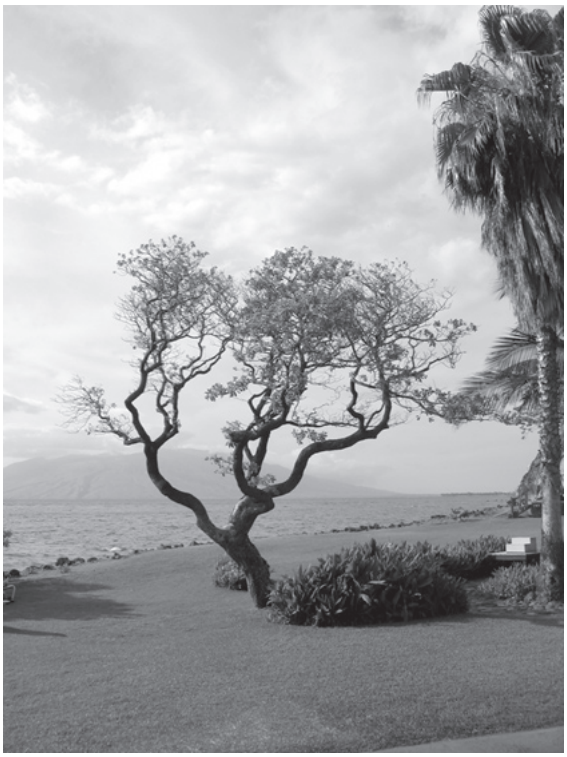
into a competitive job market. Such effects also carried forward to their children. Both the teenage mothers and the former delinquents who had made use of educational opportunities that were available to them in adulthood were eager to see their own sons and daughters succeed in school.

Marriage to a stable partner, whom they considered a close friend, was another positive turning point. Often it was a happy second marriage, after a hastily or impulsively contracted first marriage had ended in divorce. Such a marriage provided the once-troubled partners with a steady source of emotional support, and with the opportunity to share their concerns with a caring person who bolstered their self-esteem.

Conversion to a religious faith that provided structure, a sense of community, and the assurance of salvation was an important turning point in the lives of many troubled teenagers. Most of them were sons and daughters of alcoholics who had been abused as children, and who had struggled with substance abuse problems of their own.

Some individuals who had struggled with mental health problems in their teens encountered a different kind of epiphany that turned their lives around as they approached age 40. They had experienced a prolonged and painful bout with a life-threatening illness or an accident. A close encounter with death forced them to examine the lives they had lived and to consider the opportunities for positive change they would seize when they recovered.

Formal psychotherapy had worked with only a few troubled individuals (some 5%) who tended to be better educated and were of a more introspective bent. The majority in this group relied on medication that relieved anxiety or depression rather than on "talk therapy" that provided insight. The majority of the men and women consistently ranked the effectiveness of mental health professionals (whether psychiatrists, psychologists, or social workers) much lower than the counsel and advice given by spouses, friends, members of the extended family, teachers, mentors, co-workers, members of church groups, or ministers. Their low opinion of the effectiveness of professional help by mental health specialists did not improve from the second to the third and to the fourth decade of life.



Factors Contributing to the Recovery of Troubled Teens

The "troubled" individuals who made use of informal opportunities in their twenties and thirties, and whose lives subsequently took a positive turn, differed in significant ways from those who did not make use of such options. They were active and sociable, had better problem-solving and reading skills, and had been exposed to more positive interactions with caregivers in infancy and early childhood. In general, the outlook in adulthood for individuals who had been shy or lacked self-confidence as children or adolescents was more positive than for those who had displayed frequent anti-social behavior, and for youths whose parents had chronic mental health and/or alcohol abuse problems.

When we examined the links between individual dispositions and external sources of support in the family and community, we discovered that the resilient men and women were not passively reacting to the constraints of negative circumstances. Instead, they actively sought out the people and opportunities that led to a positive turnaround in their lives. The youth who made a successful adaptation in adulthood despite adversity relied on sources of support within their family and community that increased their competencies and self-efficacy, decreased the number of stressful life events they subsequently encountered, and opened up new opportunities for them.

Future Directions

Most of our findings have since been replicated in a number of longitudinal studies around the world—on the mainland in the U.S.A., and in Australia, New Zealand, Denmark, Sweden, Great Britain, and Germany (Werner, 2005). In all of these studies, one can discern a common core of individual dispositions and sources of social support that contribute to resilience. These protective buffers appear to make a more significant impact on the life course of individuals who thrive despite adversity than do specific risk factors and stressful life events, and they transcend ethnic and social class boundaries. Many of the protective factors that fostered resilience among those ex-

posed to multiple risk factors were also beneficial to those who lived in more favorable environments, but they did have a stronger predictive power for positive developmental outcomes for individuals especially challenged by adversity (Masten & Coatsworth, 1998).

Despite this accumulating evidence, the study of resilience across the life span is still relatively uncharted territory. We urgently need to explore the "reserve capacity" of older people who are an increasing segment of our population—their potential for change and continued growth in later life. Future research on resilience also needs to focus more explicitly on gender differences in response to adversity. We have consistently noted that a higher proportion of females than males managed to cope effectively with adversity in childhood and adulthood. They relied more frequently on informal sources of social support than the men. We suspect that these same gender differences may also apply to coping with old age.

We need more evidence from twin, adoptee, and family studies about the mediating effect of genetic influences that lead to positive adaptation in the context of adversity. Future research on risk and resilience also needs to acquire a cross-cultural perspective that focuses on the children from developing countries who enter our country in ever increasing numbers as migrants and refugees from war-torn countries in Africa, Asia, and Latin America.

Last, but not least, we need to carefully evaluate intervention programs that aim to foster resilience. Throughout our study, we observed large individual differences among "high-risk" individuals in their responses to adversity as well as to the opening up of naturally occurring opportunities. Our findings suggest that educational, rehabilitation, or therapeutic programs deliberately designed to improve the lives of at-risk children and youth will also have variable effects, depending on the dispositions and competencies of the participants. Thus, we should exercise some caution in advocating a particular treatment unless its effectiveness has been independently evaluated.

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References

Luthar, S. (Ed.). (2003). *Resilience and Vulnerability: Adaptation in the context of childhood adversities.* New York: Cambridge University Press.

Masten, A. S., & Coatsworth, J.D. (1998). Resilience in individual development: The development of competence in favorable and unfavorable environments: Lessons from research on successful children. *American Psychologist,* 53, 205 - 220.

Werner, E. E. (2005). What can we learn about resilience from large-scale longitudinal studies? In S. Goldstein & R. Brooks (Eds.), *Handbook of resilience in children* (pp. 91 - 106). New York: Kluwer Academic Publishers.

Werner, E. E., & Smith, R.S. (1982). *Vulnerable but invincible: A longitudinal study of resilient children and youth.* New York: McGraw Hill.

Werner, E. E., & Smith, R.S. (1992). *Overcoming the odds: High-risk children from birth to adulthood.* Ithaca, NY: Cornell University Press.

Werner, E. E., & Smith, R.S. (2001). *Journeys from childhood to midlife: Risk, resilience and recovery*. Ithaca, NY: Cornell University Press.

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Building Hope for Adolescents: The Importance of a Secure Social Base

Adolescence is a time when young people naturally work at transferring primary relational bonds from their parents to peers and romantic partners. The successful resolution of this process is critical for transitioning from childhood dependency to productive and independent adult roles. In this process, most parents strive to instill commonly accepted values and norms in their children, knowing that these standards are important for their children's future successes. These transitions are deemed successful from a societal standpoint when young people continue to be guided by these values as they enter early adulthood.

For many adolescents, however, transitions into adult roles are difficult. The frustrations and setbacks that they experience during the transition process can produce profound emotional pain. Such difficulties may be pronounced for young people with behavioral or mental health challenges. Striving to cope with mental health issues simultaneously with normal developmental tasks can make navigating social situations particularly daunting.

In this article, we show how building and maintaining hope may be particularly important for young people with emotional and behavioral challenges, because hope is a key part of both resilience and recovery. People who work with adolescents can benefit from understanding the role that hope can play, and how hopefulness can be increased, during this crucial time of transition to adulthood.

Hope as we define it (see Snyder, 2002) is a future-oriented pattern of thinking that involves the abilities to: (a) set clear and challenging "stretch goals," (b) develop the strategies or pathways to those goals, and (c) muster the necessary motivation to use those pathways to pursue objectives. All three hope components are necessary in order to successfully attain goals. Success in this context does not simply mean "getting what one wants," but rather getting what one wants in such a way that mental health benefits are maximized.

When each of the hope components is present in sufficient magnitude, people will expect to succeed. Even when they do not succeed, however, high- as compared to low-hope people are better able to cope with their failure experiences. When low-hope people fail to achieve goals, they typically cannot create alternate pathways to go around obstacles. Accordingly, these individuals with low hope are prone to give up, to criticize their own abilities, and to experience strong negative emotions. On the other hand, when individuals with high hope fail to attain goals, they simply acknowledge that they did not try hard enough or that they did not have access to the most useful pathways. Instead of becoming stuck in criticizing themselves, the high hopers get busy in finding solutions. As a result, any negative emotions experienced by high-hope people are not likely to incapacitate them. On this point, we have found that high- relative to low-hope people try harder and persevere longer after failure experiences precisely because of their abilities to retain their positive emotions.

Researchers consistently have found that high- compared to low-hope people achieve superior outcomes across a range of performance and mental health indices (see Snyder 2002, for a review). For this reason, we have suggested that having hope is vital for the successful transition from adolescence to satisfying adult roles (Shorey, Snyder, Yang, & Lewin, 2003). We also have proposed that intentionally instilling hope in young people should be a societal priority. To understand how hope can be instilled, however, we first will need to look at how hope develops naturally in the course of childhood development.

Hopeful Development

Hopeful development begins in early childhood through ongoing interactions with consistently available and responsive caregivers (Shorey et al., 2003; Snyder, 1994). Children learn that they can engage freely in exploring their environments when parents provide what attachment researchers have termed *secure bases* (See Bowlby, 1969/1982). The secure base is a safe haven to which a child can return for comfort, support, and guidance when she becomes fearful because of the obstacles that she encounters. Over time, children with secure bases will internalize beliefs in the availability of other people, in themselves as being lovable, and in the world as being a safe and predictable place. Parenting can thus support *secure attachment styles* in children. In contrast, *insecure attachment styles* can result when this type of parenting is not available. Permissive, authoritarian, and rejecting parenting styles are linked to insecure attachment. Other variables including negative life events (e.g., loss of a parent, life-threatening illness in a parent or the child, or parental psychological disorders) and wider social contexts (e.g., economic patterns necessitating parents working long hours and thereby being less available and/or less responsive) can take away children's secure bases and lead to insecure attachment.

Adolescents with insecure attachment styles are predisposed to experiencing setbacks in establishing satisfying peer and romantic relationships. For example, adolescents with "preoccupied" attachment styles are likely to place an exaggerated premium on relationship importance. When they experience relational setbacks these young people often have exaggerated negative emotional reactions. Moreover, because they are hypervigilant for potential signs of rejection, they are likely to perceive interpersonal threats even when such threats are negligible or nonexistent. Given their high levels of emotionality, they then may lash out angrily, or they may urgently seek reassurances from others. Other people, however, are likely to perceive such behaviors as aversive and withdraw their support. In this way, preoccupied individuals contribute to their experiencing that which they fear the most—rejection.

With increased perceptions of being distanced or rejected, anxiety for these preoccupied persons is likely to rise dramatically. Efforts regulate these negativ emotions and to reestablish some semblance of interpersonal security may include the preemptive rejection of others or the desperate seeking of approval order to bolster floundering self-esteems Such approval seeking may take the form of delinquent behaviors sexual promiscuity, or drug or alcohol abuse.

Of course, difficulties forming social relationships can arise in children and adolescents whose parents are warm, available, and responsive. Despite available parental support, children with emotional and behavioral problems often have difficulties with interpersonal relationships. Social anxiety, depression, impulsivity, and difficulty decoding emotional cues all may impede the development of relationships, and can result in decreasing hopefulness. Furthermore, children and adolescents with emotional and behavioral difficulties may spend much of their time coping with and managing the effects of their disorders. As a result, they may miss out on a range of opportunities to build hope or to reach important developmental milestones.

As hope for achieving commonly accepted social goals begins to wane, other goals may take precedence for children and adolescents who are struggling. Goals of belonging gradually may be replaced by goals of escaping feelings of distress and negative emotionality. Goals of gaining entry into valued peer groups may be replaced by goals of gaining entry into any peer group in which acceptance and security can be attained.

Teaching Hopeful Thinking

It is important to be mindful that adolescents who experience such rough transition phases may perceive society's representatives (e.g., parents, teachers, or school administrators) as being out of touch with the goals that are most important to them—their social goals. In this respect, contemporary psychology researchers have consistently documented the primacy of social goals and over achievement-oriented goals. This is not to say that adolescents do not understand the practical significance of being skilled in the arts of reading, writing, and arithmetic. The application of achievement-oriented academic skills, however, may seem abstract and unimportant to adolescents if they are in emotional pain because their current needs for security and belonging are not being met. For this reason, lessening adolescents' emotional pain by helping them to learn how to attain social goals may enhance their academic achievements. In this regard, interventions that increase social competence also significantly increase academic competence (Watson, et al., 1989).

We have found evidence in our own laboratory about the primacy of social goals. Among college-aged students, for example, the hope of achieving social goals (relating to friends, family, or romance) had a direct impact on positive mental health, whereas hope for achieving performance-oriented goals (relating to work or academics) did not. This and other research has convinced us that adolescents' social goals cannot be ignored if we expect them to pursue socially valued goals related to academic and career achievements. In this regard, we have developed a curriculum that is specifically tailored to raising hope among at-risk adolescents.

Our approach has been to teach hopeful thinking in a framework that emphasizes the importance of having a secure social base. We also teach adolescents to attend to their basic needs of security and affiliation as they move toward pursuing higher order goals (e.g., goals involving college educations that are wants rather than basic needs). Thus, the system of hopeful thinking that we teach is applied to the goals that adolescents view as being personally important. For example, if a young person is lonely, we work on helping him or her to develop the strategies, resources, and motivation to pursue friendships. We do not think that it would be advisable to ignore this young person's loneliness and to ask him or her to concentrate on the goals that we think are important (e.g., academics success). Experiencing success in their own personally important life areas, however, should have the effect of bolstering the drives and motivations of young people to succeed in other socially valued life areas.

Artwork by William Chen (age 11) of New Jersey
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Of course, children will be willing to try new strategies and behaviors to the extent that they have secure bases to retreat to for comfort, support, and guidance when they stumble or encounter impediments. In this regard, every child should have a consistently available adult mentor. When parents are not available, young people can rely on a caring neighbor, teacher, or other "coach" to fill this mentor role. Research has indicated that the key characteristic of resilient children is that they find their own mentors in the community (Masten, 2001). Therefore, coaching teens in social skills is important in helping them make these adaptive interpersonal connections. Moreover, adults need to be particularly attentive to the affiliative bids made by young people whom they encounter. Young people who need the most guidance may be the same children who have parents who are least able to provide it. A supportive and available "coach" can help break the mold of previous relationships and failure experiences and help teens build new roadmaps for their futures.

With mentoring and social support in place, teens can be free to focus on learning how to create and construct "adaptive" goals. Many goals that adolescents initially verbalize in our hope intervention groups are constructed in such a way that they set the teen up for failure. For example, open-ended goals (e.g., to become rich or to become a better person) are not measurable and do not have specific time frames within which they can be reached. Accordingly, the pursuer cannot know when the objective has been reached, nor can he or she experience the positive emotions associated with successful goal attainment. One of the first things that we do in our groups, therefore, is to help adolescents to frame their goals so that they are (a) measurable, (b) set in distinct time frames, (c) single goals (to get a job and make lots of

money is two goals), (d) consistent with longer-term life objectives, and (e) cause no harm to self or others.

Once goals are framed so as to facilitate success, we and other mentors are in the position to begin teaching ways to problem solve—helping teens anticipate roadblocks, develop alternative routes to go around impediments, and find new resources. Finally, supported by trusted mentors and armed with adaptive goals and strategies, teens can learn ways to bolster their own positive emotions and motivations.

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C. R. Snyder is the originator of hope theory, and is the Wright Distinguished Professor of Clinical Psychology at the University of Kansas. He has authored or co-authored over 100 books, chapters, and articles on hope.

References

Bowlby, J. (1969, 1982). *Attachment and loss,* (2nd ed., Vol. 1) New York: Basic Books.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist, 56,* 227-238.

Shorey, H. S., Snyder, C. R., Yang, X., & Lewin, M. R. (2003). The role of hope as a mediator in recollected parenting, adult attachment, and mental health. *Journal of Social and Clinical Psychology, 22,* 685-715.

Snyder, C. R. (1994). *The psychology of hope: You can get there from here.* New York: Free Press.

Snyder, C. R. (2002). Hope theory: Rainbows in the mind. *Psychological Inquiry. 13,* 249-275.

Watson, M., Solomon, D., Battistich, V., Schaps, E., & Solomon, J. (1989). The child development project: Combining traditional and developmental approaches to values education. In L. Nucci (Ed.), *Moral development and character education: A dialogue* (pp. 51-92). Berkeley: McCutchan.

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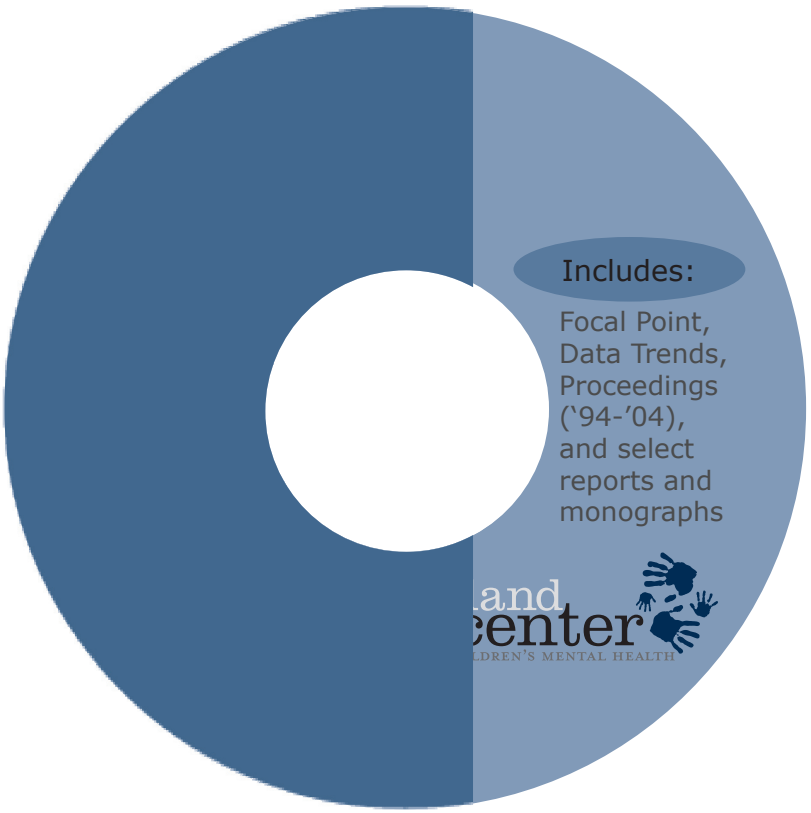

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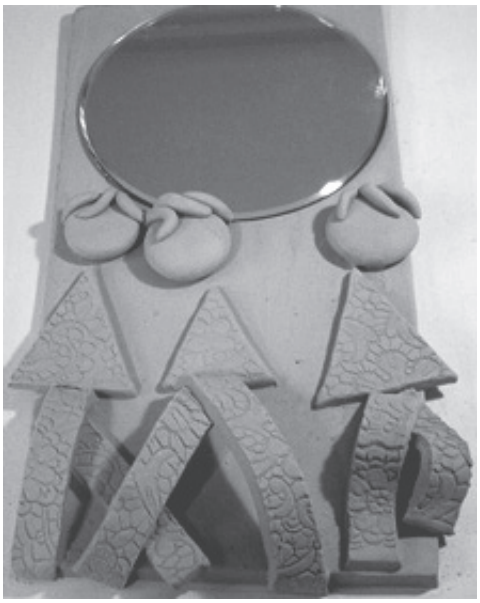
Surviving the System

My name is Angela Nelson, and this is the story of my survival. I grew up in the child welfare system in Illinois, spending most of eleven years in psychiatric institutions and group homes. I can honestly say that the system did not help me recover from any of the problems I came in with; in fact, it created additional difficulty. The system focused on controlling my behavior with little regard to the issues that brought me into the system in the first place. In particular, I received very little education and there was no effort to keep my family unit together. Despite the lack of regard for my future, I still maintained hope and I am living independently today. I know reaching my goals will be difficult, especially since there are few resources and little support available to me now.

My mother had me the month after her 14th birthday. My father was 19. My mother's father told her to have an abortion, but she decided that she wanted to keep me, and ran away to Memphis to live with her mother. My mother left me with my grandmother until I turned six. My mother had turned 20, and decided that she could take care of a child. She fought for custody, and I came back to Chicago to live with her and my stepfather. About seven months after I came to live with her, my stepfather left. Although I didn't know it at the time, they had had an arrangement to suit both of their needs. She needed to show she had a stable home and he needed to obtain citizenship.

After my stepfather left, things went downhill rapidly. I went from



one relative's home to another and occasionally I lived with my mother. When I lived with her, she beat me and left me at home by myself. There were times when I told the public defender that I didn't want to be at home with my mother because she was beating me. He said he couldn't just take a child away from her home because she didn't want to be there. But I kept telling him it was because she was beating me. I definitely had been involved with the system before I came into the system. But the system kept sending me back to her.

At the age of ten, almost eleven, things seemed somewhat normal. Then my uncle came to live with us. He started sexually abusing me and I told my teachers about it. He was removed from my house. The system didn't offer us any support. About a month later, my mother asked me to clean my uncle's room. I turned over the mattress and I saw a *Playboy* magazine and some matches. I lit the matches and put them on the bed. I went into the system after I set my house on fire. I never understood why I set my house on fire until years later, when I realized my mother probably would have eventually killed me if I had stayed at home. I think deep down inside, I realized that was my way out.

Little did I know that once I came into the system my problems had not even begun. Coming into the system with a label such as a fire setter sometimes prevents people from seeing who you really are. They really can't see past that label. I really think I was a decent kid and years later, my mother said I was a pretty good kid. Damn right—I *was* a good kid.

I got into the system and the first place I landed was a psychiatric institution. I spent 11 months there. From the medication to the seclusion to the restraints, how was I supposed to adjust? I was surrounded by people I didn't know:

nurses, doctors, psychiatrists, and other children who also had behavior problems. It was an unrealistic adjustment I was supposed to make. Needless to say, I didn't do too well adapting. Of course, more labels followed. I rarely saw anybody from my family. I saw my mother once or twice. My teachers came to visit me once. My grandparents came to see me once. I saw none of my cousins, aunts, or uncles. To this day, I just cannot comprehend how I survived my world being flipped upside down like that. But of course since I didn't handle it well, I was the one who suffered.

I got out of the first institution and I went to a group home. More strangers. I stayed there for three months. I believe I had so many unresolved issues that, before I could be anyplace successfully, the issues that brought me into the system would have to be addressed outside of a pill bottle. But that's clearly not what my treatment plan was. Therefore, since I desperately needed to be in control of my own existence, we battled. And they always won because they had the ability to give me shots, pills, restraints, and seclusions anytime I resisted, questioned, or disobeyed their nonsense.

After leaving the group home, I went back to the hospital for three months. That was just more of the same old nonsense of them controlling my existence. I left there and went to another group home for three weeks. Still, nothing had been resolved and I was 13 at this time. The issues that got me into the system were no longer the issues at hand. I was faced with a whole new set of issues. The system wanted to control me, and I resisted.

I left the group home and I went back to the hospital. My father's mother tried to get custody of me. Needless to say, she was not a winner. Let's just put it like this–it wasn't a good match. But at least I wasn't in the hospital. One day I got into a fight at school. The school called my grandmother, but she was not at home. Since she was not at home, they called my social worker. She came to the school with another social worker. On the way to my grandmother's house, I told her that I wanted to get out of the car because I could go home by myself. She disagreed, and we fought. This fight with my caseworker at 14 years of age landed me a 4-year stay in a state hospital. Needless to say, the restraints and the seclusion and the medication that I experienced earlier in life do not compare to the seven days in restraints and another three days in restraints and the endless amount of medication and the countless hours in seclusion. If I could do it all over again, I would have stayed at my mother's house and let her continue to beat me and let my uncle continue to sexually abuse me. By the time I got out of this institution, I can assure you if I didn't have mental health issues before I went in, I had them now.

When I was discharged from the hospital, I went to a group home in Denver. Of course, that didn't last very long. I returned to Chicago to the adult hospital. We all know that's a different ball game. I was thrown right into the mix of people there, many with serious mental illness. Thank goodness I had found a psychiatrist who was actually willing to listen to me. When I told him I didn't need medication, he said OK. He told me that if a staff member asked me to go to my room and I didn't get out of control, they wouldn't put me on medication. I haven't taken a pill since. Of course, since I had such a stellar record, programs in Chicago weren't exactly eager to take me. So I spent six months in the adult psychiatric institution. Not because I needed to but because I had no place to go.

Once the Department of Children and Family Services did find a place for me, they expected me to live alone and to basically take care of myself. Thank goodness for me there actually wasn't too much wrong with me. I have always thought I got caught up in the system. I got labeled because of my behavior, and I never had a chance after that. Unfortunately for me, I was just as uneducated when I came out of the system as I was when I went in. So I didn't have many skills or any money. I ended up on social security, yet again a financial burden to the system.

In all of this, I did come out with a wonderful gift for the arts. I was able to recognize an opportunity when I saw one. I was walking down the street one day and I saw a sign that stated, "Do you want to learn how to make tiles for free?" Being interested in the arts and not having money for materials, this was an opportunity to be creative at somebody else's expense. It was a great success. It gave me hope that I actually could do something meaningful with my life. Today I feel much better about studying for the GED because I have succeeded in something in another part of my life. I am good at art and it gives me a good sense of myself. Although there have been a lot of ups and

downs in my life, I knew I could shape my own world and I have done so with the help of my creativity. I have been able to supplement my Social Security money with the sales of my artwork. Of course, making a living that way is hard, so I have been working toward my GED so that I will have more employment options. I failed the GED three times, but I am hoping to pass it this June. I am also working on a book that I plan to finish this year.

I would like to close by saying this: if people in the system could have looked to the future and could have seen both me and my mother as productive members of society, they could have given my mother some parenting classes, helped her get some kind of skill or trade, and helped to educate me. We could be productive members of this society. Instead, she's on Social Security and she receives food stamps. I, too, am on Social Security and I receive food stamps. We are both still uneducated.

The system has to meet real needs in order for people to truly function in this society, especially if they already have challenges. If you take a child from a mother and do nothing with the child, what is the point? If I had gotten some of the right kind of help at the beginning, much of what I suffered could have been avoided. So if you're trying to help children and families, look towards their futures to see what it is you can do to help them be successful when the system has left their lives five or ten years from now.

Angela Nelson lives in Chicago. Her artwork can be viewed at www.geocities.com/angelasceramics/tiles.

Supporting Recovery for Older Children and Adolescents

For children and adolescents, recovery is best understood as a process that enables the young person and his or her significant adults to understand and manage the realities of an emotional disorder, so that the young person can return to a positive developmental path. Recovery starts from the idea that young people have within them capacities that will, if unleashed, propel them on a constructive developmental course. Recovery-oriented therapeutic services facilitate the efforts of children and youth to connect with their strengths and capacities as drivers of positive development. Recovery-oriented services also focus on providing opportunities for children to participate, free of stigma, in activities alongside peers and adults who comprise their community. An essential part of this work is empowering parents—and other significant adults in the youths' lives—in their roles as the primary facilitators of the recovery process.

A functioning system of care and a high fidelity wraparound process provide the ideal context for supporting recovery. The system of care values and principles—with their focus on individualization, cultural competence, family empowerment, and strengths—are inherently in tune with a recovery approach. For individual children and their families, the wraparound process addresses the challenges of working around limitations from an illness or disorder and getting on with the process of growing up. Within this context, strengths-based, culturally competent, individualized treatment can thrive and conform to the core values of recovery.

The Experience of Recovery

Older children and youth rarely embrace the role of "mental health patient" as they enter treatment. They are more comfortable playing, or talking about their social world; and they have neither the vocabulary nor the inclination to discuss the concept of recovery. It is a therapist's task—in consultation with parents, their child and, if available, a wraparound team—to find ways to help the child *experience* the recovery process. Consider this example:

Ted, an unhappy 10 year-old boy, avoided all talk of his feelings and of his family circumstances. His father was in prison. Ted missed the good times he had with his father fishing in the lake near their home. Although those times were precious few, the boy was full of stories of catching the biggest and best fish. Ted's therapist had him bring his fishing gear to his office and worked with the boy to untangle lines and get ready for a fishing trip. His mother, with a wraparound team's support, had connected her son with a peer group that took monthly outings with a youth recreational worker. Ted and his mom had suggested a fishing trip as an activity and the "therapy" was understood by the boy as preparing for that trip. While untangling fishing line prior to the trip, Ted had important conversations with his therapist about school, about his mom and siblings, and occasionally, about his dad. The therapist allowed the boy to avoid emotionally overwhelming topics and kept emphasizing the boy's capabilities in organizing fishing tackle. With support from the youth leader, Ted had a great experience. On the trip he gained status among the other boys as a fishing expert, and this left

him confident as a leader. When he returned, his mother was impressed with her son's swagger and confidence, as well as with the fish he brought home. Fishing stories became a way for him to enjoy being in school. He gladly adopted the nickname "Fish" with his friends.

Ted never once heard the terms *recovery*, *resilience* or *protective factors*. He would have been bored and put off by any such talk. Yet he was in a position to teach all the adults in his life what a strength-based approach can do for a withdrawn and depressed boy. He found a way to reconnect to a developmental process, identifying with positive aspects of his father, incorporating such attributes into his growing personal identity, and earning respect for his capability. Ted was also placed on an antidepressant medication and monitored by a doctor who knew about the boy's love of fishing. That doctor enabled Ted to see that the medication had a positive effect on his patience, which in turn increased his fishing success. A doctor can be perceived as an ally when offering a medication that further diminishes the implications of a mental health problem and enables a youth to engage more fully in developmentally appropriate activities.

Risk and Recovery in Adolescence

The developmental tasks of adolescence are primarily social, as young people change the focus of their lives from family to community and from parents to peers. The presence of a mental illness in adolescence often distorts this social-developmental process. On the one hand, it can lead to a youth being more dependent on parents than is age appropriate. Alternately, it can lead to a teen being defiant to parents in a way that increases risk for further social and mental health difficulties. It is often a central therapeutic task to help the young person and his or her family to navigate between these extremes, as in this example:

Erin, an unhappy girl who was failing in school, had recently been diagnosed with bipolar disorder. Her drinking in peer situations had gotten out of control. She began to act in a more and more outrageous and disrespectful manner toward her mother, defying the curfew her mother had set for her and sneaking out of her window at night to be with friends. Erin was very aware of her irritable mood, which was painful to her as she recalled the good-natured, fun kid she had been before. Though terrified she was "going crazy," she refused to acknowledge any problem to anyone. Her means for coping with excess energy had been sports, and she held her life together during basketball season by playing and exercising regularly. After basketball season, she began going to raves, taking ecstasy and dancing with enormous energy.

After a while, Erin's problems began to spill over into her peer world. She got drunk at a party and engaged in public sexual behavior with a boy. The high school gossip mill spread word of the incident, providing her instantly with a bad reputation. Some of the cool kids shunned her, and new, more troubled boys wanted to be her friend. Erin began to sink into self-hatred, cutting herself, and imagining gruesome ways to commit suicide. Eventually Erin's mother convinced her to accept a hospitalization. The experience only increased her rage as she was given a mood stabilizer that caused her to rapidly gain weight. The only positive outcome was that she was able find a psychiatrist she could work with once discharged.

The new psychiatrist helped Erin's mother get into a parent support organization where she encountered other parents who had faced similar problems with their children. The psychiatrist wasn't shocked or judgmental about Erin's difficulties and Erin was relieved to be able to disclose her thoughts and feelings. Her particular concerns were the cruel comments boys had made to her and the loss of status she experienced with girls who had formerly been her allies. After some explanation about bipolar illness and the medications she might find useful, Erin was very open to re-trying a mood stabilizer. She was grateful to her psychiatrist for not giving her a medication that would cause her to gain weight.

Erin's medications quelled her constant irritability. She began to exercise more and feel better. She stuck close to her good friends who defended her amongst her classmates. She continued to go to parties, but friends refused to let her drink. She continued to fight with her mother, who was determined to curtail Erin's risky behavior. Erin resisted and defied her mother's attempts to ground her. Friends came to the house to talk to Erin's mother and assure her that her daughter was beginning to take care of herself. They promised her that

they would not let Erin endanger herself. Erin's mother made some compromises with her daughter as she sensed the constructive nature of her daughter's relationships with friends. Erin stuck by her agreements regarding a very liberal curfew and was supported in doing so by her good friends. As the climate of hostility began to change, Erin and her mother had a long tearful night that ended in reconciliation.

Gradually, Erin's mood improved and she began to seek some accommodations from her school so that she could salvage her spring semester. She continued to go to raves because she loved to dance, but she went with a good friend and found she could enjoy dancing without ecstasy. She became a peer mentor to others and participated in a youth group that intervened to keep other youth safe at parties. Her mother, though wary of such social events, grew to respect Erin as she proved her capacity to handle social events responsibly. Erin's mother also became active with other mothers seeking more constructive and safe social outlets for youth in their community.

With the support of the therapist, peers, friends, and family, Erin was able to re-engage with a healthy and normal (for her community) developmental process. However, Erin never really thought of herself in treatment and certainly never contemplated the concept of recovery. The mental health professional may *call* it a recovery process, but the young person *lives* a recovery process. Youth simply know when things are screwed up and when they get it together.

Treatment that Supports Recovery

Treatment that supports a recovery process for teens must be supportive of developmentally appropriate moves for more independence and privacy within their family. An effective therapist recognizes that youth are going to experiment with behavior that is normative, developmentally, even though it may carry extra risks for someone with an emotional disorder. Dating, engaging in sexual experiences, experimenting with drugs and alcohol, and experiencing the liberating feeling of being in an unsupervised group of youth edging toward out-of-control behavior—these are all experiences that are part of normal adolescence. A therapist can help the young person learn to manage the risks that are inherent in these activities and to participate in youth culture in a manner that makes sense, given the young person's particular needs. This is done through education and negotiation about the kinds of accommodations a youth must make for his or her illness. This process demands a high degree of confidentiality for the youth, but also a close alliance with parents who, understandably, have fears for their vulnerable son or daughter. An important facet of the therapist's role with an adolescent in recovery is to help the youth negotiate with parents regarding reasonable limits, and to help the parents avoid inappropriately limiting their adolescent child out of fears stemming from the illness or disorder. Parents suffer most from quandaries that arise around potential sources of risk. With good reason, they see unsupervised social activity among teens as risky, and it is a parent's job to be alert for signs of such behavior running out of control. But risk is also a part of the fabric of experiences that allow youth to grow and mature.

Professionals sensitive to the principles of recovery in youth can be invaluable allies with young people as they move toward restoration of the developmental process. To do this effectively, professionals need to be able to help young clients recognize and build on their strengths. Additionally, professionals must have the ability to support their young clients in learning to appropriately engage in the types of situations and relationships that are part of the normative developmental process. Professionals must also understand the families their youthful clients come from and recognize that young people love their families no mater how disguised that love may be. Finally, professionals must be able to help the young person and his or her significant adults work together. With these capacities, a professional can facilitate a recovery process that engages a young person's assets and allies, and promotes a return to a healthy developmental path.

Charles Huffine is a Seattle child and adolescent psychiatrist who has a private practice devoted to treating adolescents. He is also Medical Director for Child and Adolescent Programs for the mental health system in King County, Washington.

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RESILIENCE *AND* RECOVERY: CHANGING PERSPECTIVES AND POLICY IN OHIO

Beginning in the mid-1990s in Ohio, adult mental health consumers began to have an increasing impact on the state's mental health policy. Leadership within the Ohio Department of Mental Health began to work with adult consumers and, at the same time, consumer advocacy networks were strengthening. Adult consumers promoted the idea that services should focus on recovery.

Advocating for children and families, the Ohio Federation for Children's Mental Health had representatives at the table when these initial discussions about recovery were taking place. Family advocates supported the recovery philosophy, but at the same time felt that the recovery concept did not draw attention to some of the issues that are particularly important for children and families. They kept pointing out that children are not just little adults, that the mental health services and systems for children and adults are very different, and that the philosophy of recovery simply did not connect with some of their central concerns.

One difficulty families had with *recovery* is that the word implies going back to what existed before. For families and children, going back to a time before the mental illness or the mental issue began to impact life is not an option. If your child has been struggling for two or three years and is now six years old, the goal is not to restart the developmental process at age three, but to recoup those years as part of the process of moving ahead. To support this kind of ongoing development—this moving ahead in the light of emotional or behavioral difficulties—mental health services and supports need to be built on the cornerstone of hope, and they need to focus on using and developing the strengths of the young person and the family so as to build a full life.

Resilience

For family members, the idea of *resilience* captures this vision best. Resilience brings attention to the strengths of the child as protective factors and as assets for the process of positive development. Resilience also draws attention to the family as the most important asset a child can have. Family advocates felt it was essential for the state to place resilience on an equal footing with recovery as a guide for mental health policy and practice. They felt that a resilience orientation would help to bring about changes that were in line with the two central elements of their vision for transforming Ohio's mental health system: the empowerment of families and youth at all

levels of the service system, and the focus on hope and strengths.

Initial attempts to get the state to recognize the importance of the concept of resilience were not particularly successful. Family advocates would use the term resiliency, and providers and policymakers would nod their heads and then just go right back to whatever they had been talking about before. But four or five years ago, things began to change with the gradual shift toward a greater voice for families and youth in various state-level planning and decision making arenas such as the Mental Health Planning Council and the Clinical Quality Council. Family advocates used those venues as opportunities to keep reminding people—adult consumers, mental health providers, and state policymakers—about the issue of resilience.

Then, with the publication of the final report from the President's New Freedom Commission, things finally began to change. The report validated what family advocates had been saying all along about the need to focus on resilience. At about the same time, the Department of Mental Health developed consumer-family partnership teams as a means to increase consumer and family voices in policy decision making. The Department of Mental Health allocated funds so that consumers and families from across the state of Ohio can get support to pay for their transportation and their hotels. This means that they can be at the table when policy is made. The goal is to have 50% consumers and family members and 50% Department people or providers at the table. While attaining this goal is still in the future, it has provided a wonderful opportunity for families to speak out and for youth to be involved. The state is working on policies that require a public arena for family input whenever there is a new initiative in the state that impacts them. These are mechanisms that promote inviting, recruiting, and supporting families and youth to give their input and opinions.

All along, the Ohio Federation for Children's Mental Health kept using its voice to promote resilience and to pressure the state to get serious about it. Two years ago family advocates developed a proposal asking the Department to fund a series of forums across the state. The forums invited young people and their families to come and talk about resiliency and to describe what had been most important in giving them hope and making their lives better. With state funding, six of these forums were held across the state. Data was compiled and given back to the Department.

What was learned during the forums was wonderful and also surprising. One might expect that folks would give most attention to the service system or the lack of services. They did comment on services, but what was surprising to the facilitators of the forums was how much of what youth and families said could have come straight out of a book on developmental assets. They were talking about the importance of having an adult just to talk to, the importance of supportive relationships in the family, and the need to feel a sense of acceptance and belonging at school and in the community.

The Resiliency Ring

Advocates were determined not to allow the state just to sit on this great information. After about a year, advocates decided they needed to do something independently to draw further attention to the issue of resiliency. To do this, family advocates organized a public relations event in Columbus and called it the *Resiliency Ring.* The event started with a rally at the capitol, with speakers including the head of the Department of Mental Health and a young woman who was a suicide survivor. Several state legislators came, as did Hope Taft, Ohio's first lady. Also present were families from all over the state and people from a number of advocacy organizations. The highlight of the rally was when attendees held hands in solidarity and formed the Resiliency Ring, encircling the capitol building. After the rally, advocates paid a personal visit to every legislator and provided him or her with a packet of resiliency-focused literature. Advocates spent time with the legislators, providing an overview of findings from resiliency studies and talking about the policies and issues that tie into a resiliency framework.

The Resiliency Ring was a huge success and received quite a bit of attention in the media. The event seems to have had a real impact too. In a budget full of cuts, one bright spot is a carveout for children's mental health that includes increased support for family advocates to work directly with families. What is more, it has become rare to see policies or administrative rules coming from the state that do not use the words resiliency and recovery together. The Federation has been working with the state to develop a definition of resiliency that is workable and that resonates with families and young people.

Of course, there is still much to do in terms of building a mental health system that knows how to foster hope and build strengths. At the same time, progress is obvious. The terminology of resiliency is becoming embedded in Ohio's mental health policies and standards. Advocates continue working to broaden people's understanding of mental health and to help them see that there are many creative ways to promote positive development and wellness.

The image at the beginning of this article is the logo for the Resiliency Ring.

This article was written by **Janet S. Walker**, based on an interview with **Terre Garner**, Director of the Ohio Federation for Children's Mental Health.

Developmental Assets and the Promotion of Positive Development: Findings From Search Institute Data

The healthy development of youth is a value and a goal of American society. Families, schools, and communities are charged with nurturing, socializing, and educating children to be competent, happy, positively contributing members of society. However, the theory and research traditions associated with psychology—developmental psychology in particular—have historically been framed within a deficit perspective regarding youth.

G. Stanley Hall (1904) initiated this deficit perspective with his description of adolescence as a time of inevitable storm and stress. Similarly, Anna Freud viewed adolescence as a period of developmental disturbance, and Erik Erikson believed that youth identity was born of crisis. Under the influence of the deficit perspective, much of the research and theory about youth development has emphasized a medical model that focuses on the diagnosis and treatment of problems. In addition, the data collected on youth and the media's portrayal of youth have often stressed problems, risk behavior, and challenges. In response, interventions and programs for adolescents have often focused on specific problems or disorders. However, this approach detracts from viewing youth holistically, and as possessing hopes, purpose, and skills, as well as problems and challenges. Moreover, viewing youth as the target of change overlooks the importance of the multiple contexts youth inhabit. These contexts also have strengths that can be engaged to promote healthy development and recovery from adversity.

Research in the 1980s and 1990s began to focus on the study of *positive youth development* (PYD). This approach emphasizes the potential in every individual for positive, healthy growth across the life span, regardless of socioeconomic situation, past negative experience, or clinical diagnoses. Instead of trying to fix problems, the PYD approach considers ways to develop individuals *and* social contexts through strengths-based policies and programs and through the empowerment of youth and families. Research derived from this perspective seeks to align children, families, and communities with growth-supportive resources, opportunities, and experiences, leading to healthy development and thriving.

The PYD approach views adolescence as a period of the life cycle with unique opportunities for developing assets and putting young people on a positive developmental path. Youth are viewed as eager to explore the world and build competencies (Damon, 2004). From this perspective, youth who have experienced mental health issues need not only treatment, but also growth-promoting, challenging activities that help develop their identities, skills, and interpersonal relationships. Of course, developmental challenges and adversities do exist; however, they do not define the adolescent and determine all treatment and interactions.

Impact of Developmental Assets

Benson and colleagues (1998) at the Search Institute have proposed a framework of 40 developmental assets, with 20 internal assets (unique to the individual), and 20 external assets (available in youths' families, schools, and neighborhoods) that promote healthy growth among young people. Benson et al., believe that when these external assets (e.g., support, empowerment, boundaries and expectations, and constructive use of time) are integrated over time for youth with internal assets (e.g., commitment to learning, posi-

Table 1: Fourteen Developmental Asset Scales

Developmental Assets	Definition
Individual Asset Scales	
Social Conscience	Being committed to equality, social justice, and helping to make the world a better place
Personal Values	Committing to values such as honesty, responsibility, and integrity
Interpersonal Values and Skills	Caring about other people's feelings, demonstrating empathy, and being a good friend
Risk Avoidance	Making good choices when confronted with risky situations (e.g., "Being able to say no when someone wants me to do something that I know is wrong or dangerous")
Activity Participation	After-school involvement in clubs, organizations, sports, and lessons
Positive Identity	A sense of self-esteem and self-efficacy
School Engagement	Being prepared for school by completing homework and bringing books and materials to class
Connection to Family	Interactions with family members include support, communication, and love
Adult Mentors	Having relationships with caring adults whom one looks forward to spending time with
Connection to Community	Being part of a community that values what youth have to say
Parent Involvement	Parents are active participants in schooling—attending events, asking about homework, and encouraging youth to do their best
Connection to School	Having caring teachers, receiving encouragement, and caring about the school one goes to
Rules and Boundaries	Experiencing appropriate and fair boundaries at home, at school, and in the neighborhood
Contextual Safety	Perceiving that one's family, school, and neighborhood are safe and free from danger

tive values, social competencies, and positive identity), then mutually beneficial individual youth ⇔ community context relations are created, providing young people with the resources needed to build and to pursue healthy lives. The model attempts to describe what is universal and good for all youth. However, it is important to note that developmental assets may have different meaning, value, and impact for diverse youth, families, and communities.

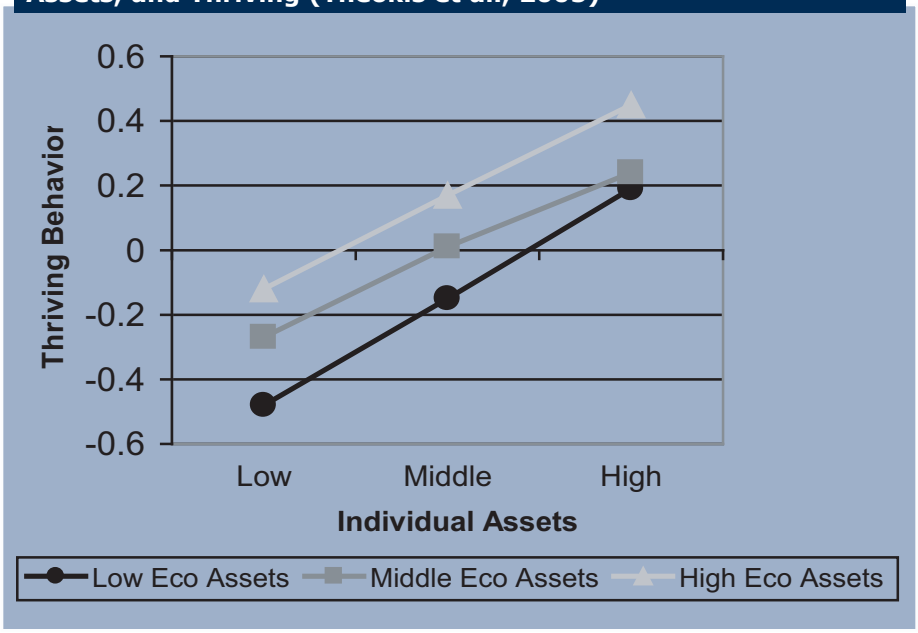
Data from the Search Institute (Benson et al., 1998; Leffert et al., 1998; Scales et al., 2000) regarding the impact of assets suggests there is an additive or cumulative effect of the total number of assets on positive outcomes. Using a sample of more than 200,000 youth in grades 6 to 12 from across the United States, the findings indicate that the more assets a young person reports experiencing, the more likely he or she is to report engaging in thriving behaviors (e.g., helping others or school success) and the less likely they are to report engaging in high-risk behaviors (e.g., delinquency or substance abuse). These relationships are consistent for youth of all socioeconomic strata and racial/ethnic groups. However, the absolute number of developmental assets and thriving risk behaviors do differ among groups, demonstrating the different needs and experiences of youth in the United States.

The Search Institute data also indicate that youth report only having about half or less of the 40 total assets (average = 18) and the total number of assets tends to be lower for high school youth as compared to middle school youth. Some assets show steeper differences than others and may represent contrasting developmental needs of youth in different grades. In addition, boys generally report having fewer assets than girls. This difference may arise from the reporting approach or may reflect different socialization practices and expectations.

The cumulative power of developmental assets for the promotion of thriving behaviors and reduction of risk behaviors is consistent with the PYD vision of how to strengthen the capacities of youth. However, it is also important to understand the unique contributions of specific assets for diverse youth. Youth after-school activity engagement (e.g., involvement in school activities, sports, or community clubs) was the most consistent predictor of positive outcomes for youth of all racial/ethnic backgrounds, when socioeconomic status, gender, and grade were controlled for in statisti-

cal analyses. These activities are hypothesized to include skill-building activities with adult mentors, which are believed to meet youths' developmental needs for competence and positive social bonds. This finding coincides with Eccles and Gootman's (2002) emphasis on the growing importance of community programs as an asset for youth, given America's changing social structure (e.g., more single-parent households) and the increasing education and training needs of youth in our progressively more complex and technological world.

Figure 1: Relationship between Individual Assets, Ecological Assets, and Thriving (Theokis et al., 2005)



Planning and decision-making skills, as well as self-esteem, were also strong predictors of many positive outcomes for diverse youth. In addition, for youth of color, family variables (e.g., provision of support) and community variables (e.g., presence of adult mentors) were significant contributors to thriving. Future research must continue to describe which attributes, of which youth, in relation to what contextual settings, promote thriving.

It is important to note that the 40 assets do not work in isolation, and that there are strong relationships among assets due to the unique cultural niches of youth. For example, school engagement by youth occurs in relation to a caring school climate and high expectations by teachers. To explore the nature of the interrelation among developmental assets, we did a reanalysis of the Search Institute developmental assets data. Theokas et al. (2005) found that the 40 developmental assets could be reduced to 14 asset scales. These scales could be grouped into two categories of seven scales each, representing individual and ecological assets, respectively (see Table 1). Each of these scales combines several assets from the original 40-asset framework, and each scale represents a major category of influence for youth development. Higher scores on each individual scale are related to higher thriving scores.

Moreover, both individual and ecological assets contribute to thriving behaviors. As can be seen in Figure 1, having high assets in either domain increases the likelihood of youth thriving and having high assets in both domains predicts the highest levels of thriving.

Building Opportunities for Thriving

The PYD approach and the construct of developmental assets associated with it are intended to replace the traditional problem-focused paradigm about adolescent development and to help communities and practitioners plan and organize different programs and policies to benefit youth and families. The asset concept orients individuals towards what is good and possible across development. This emphasis reduces the likelihood of stigmatizing youth who have experienced adversity—including mental health challenges. It also provides new avenues for fostering resilience and recovery by identifying many ways to mobilize developmental assets, not just of the individual and family, but also of the community.

The PYD approach and the assets concept use community as an organizing principle. Community ties together multiple, intersecting individuals, relationships, and institutions. Interventions that are confined to a setting (e.g., school reform) or to a problem (e.g., juvenile delinquency) are missing out on multiple opportunities to engender positive change. Multiple, positive social influences throughout an individual's life are needed to maximize motivation, learning, and healthy growth.

The writing of this article was supported in part by a grant from the National 4-H Council.

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References

Benson, P.L., Leffert, N., Scales, P.C., Blyth, D.A. (1998). Beyond the "Village" rhetoric: Creating healthy communities for children and adolescents. *Applied Developmental Science, 2*, 138-159.

Damon, W. (2004). What is positive youth development? *The Annals of the American Academy, 591,* 13-24.

Eccles, J. S., & Gootman, J. A. (Eds.). (2002). *Community programs to promote youth development.* Washington, DC: National Academy Press.

Hall, G. S. (1904). *Adolescence: Its psychology and its relations to physiology, anthropology, sociology, sex, crime, religion, and education.* New York: Appleton.

Leffert, N., Benson, P. L., Scales, P. C., Sharma, A. R., Drake, D. R., & Blyth, D. A. (1998). Developmental assets: Measurement and prediction of risk behaviors among adolescents. *Applied Developmental Science, 2,* 209-230.

Scales, P. C., Benson, P. L., Leffert, N., & Blyth, D. A. (2000). The contribution of developmental assets to the prediction of thriving among adolescents. *Applied Developmental Science, 4,* 27-46.

Theokas, C., Almerigi, J., Lerner, R.M., Dowling, E., Benson, P.B., Scales, P., & von Eye, A. (2005). Conceptualizing and modeling individual and ecological asset components of thriving in early adolescence. *Journal of Early Adolescence, 25,* 113-143.

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