Support Services for Young Adults With Substance Use Disorders

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abstract

In summarizing the proceedings of a longitudinal meeting of experts in substance use disorders (SUDs) among young adults, this special article reviews principles of care concerning recovery support services for this population. Young adults in recovery from SUDs can benefit from a variety of support services throughout the process of recovery. These services take place in both traditional clinical settings and settings outside the health system, and they can be delivered by a wide variety of nonprofessional and paraprofessional individuals. In this article, we communicate fundamental points related to guidance, evidence, and clinical considerations about 3 basic principles for recovery support services: (1) given their developmental needs, young adults affected by SUDs should have access to a wide variety of recovery support services regardless of the levels of care they need, which could range from early intervention services to medically managed intensive inpatient services; (2) the workforce for addiction services for young adults benefits from the inclusion of individuals with lived experience in addiction; and (3) recovery support services should be integrated to promote recovery most effectively and provide the strongest possible social support.

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The guidelines/recommendations in this article are not American Academy of Pediatrics policy, and publication herein does not imply endorsement.

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Young adulthood (defined as ages 18–25 years) is defined by significant transitions from the dependence of adolescence to the independence and responsibilities of adulthood.[1,2] Substance use peaks during young adulthood,[3] and a significant body of research exists regarding factors associated with its onset, such as unemployment, lower education, and noncustodial parenthood.[4–6] However, less attention has been paid to the unique needs of young adults in recovery from substance use disorders (SUDs) and how best to promote the recovery process for this particularly vulnerable population.[7]

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential.[8] According to SAMHSA, a successful recovery hinges on 4 key dimensions: (1) overcoming or managing one's condition and symptoms; (2) having a stable and safe place to live; (3) conducting meaningful daily activities and having the independence, income, and resources to participate in society; and (4) having relationships and social networks that provide support, friendship, love, and hope. SAMHSA's definition of recovery implicitly recognizes the complex interplay among the individual, family, community, and other social factors that influence the trajectory of recovery.

Recovery capital refers to the breadth and depth of internal and external resources that can be drawn on to initiate and sustain recovery from alcohol and other drug problems.[9] Recovery capital is conceptually linked to a broad range of recovery-related terminologies such as natural recovery, solution-focused therapy, strengths-based case management, recovery management, resilience, and the ideas of overall wellness and global health.[10] This comprehensive view of recovery resources has been further subdivided into 3 types of recovery capital, including personal capital (an individual's physical and human capital such as physical health, financial assets, health insurance, safe shelter, food security, transportation, education and/or vocational skills, self-esteem, and confidence), family and/or social capital (intimate relationships, family and kinship relationships, and social relationships such as partner and family support), and community capital (community-level attitudes, policies, and resources such as education and training, employment, housing, legal counseling, role models, and culturally prescribed pathways of recovery).[10]

The resources, or capital, that an individual person needs depends on the severity of the individual's SUD and the resources the individual already has available. From a social-ecological perspective,[11] it is necessary to act across multiple levels and dimensions to sustain full recovery over time and ensure long-term success. SAMHSA has advanced the framework of Recovery-Oriented Systems of Care, which proposes a multisystem, person-centered continuum of care in which a variety of coordinated support services are tailored to patients' recovery stage, recovery pathway, and needs.[12]

The focus of recovery support services is responsive to calls from the National Academy of Medicine for a change from an acute care model to one typically used for chronic conditions.[13] The full range of recovery support services is intended to address the multitude of life areas in response to patients' changing needs. Conceptually, the dimensions of recovery support services call for promoting partnerships with people in recovery from SUDs and their family members to promote individual, program, and system-level approaches that foster health and resilience. These approaches include helping young adults with SUDs be well, manage symptoms, and achieve and maintain abstinence; increasing housing to support recovery; reducing barriers to employment, education, and other life goals; and securing necessary social supports in an individual's chosen community.

Considering this array of recovery support services and potential delivery systems to support them, a group of experts was convened as part of a longitudinal meeting, supported by Boston Medical Center's Grayken Center for Addiction Medicine, to derive principles of care related to recovery support services for young adults. In this article, we communicate fundamental points related to guidance, evidence, and practice considerations about 3 basic principles for recovery support services to promote young adult recovery. The recommendations in this article are not American Academy of Pediatrics policy, and publication herein does not imply endorsement.

PRINCIPLES OF CARE

Principle 1: Given Their Developmental Needs, Young Adults Affected by SUD Should Have Access to a Wide Variety of Recovery Support Services Regardless of the Levels of Care They Need

Guidance

A key premise underlying recovery support services is that SUD is a chronic condition.[14] As a result, clinicians caring for young adults with SUD should recognize that the recovery process takes place primarily outside conventional medical settings. A treatment model that focuses on acute care, or that takes place in isolation from other community-based services, is at odds with longitudinal studies that indicate that more than half of patients entering publicly funded addiction programs require multiple episodes of treatment over several years to

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achieve sustained recovery[15] and that the recovery process is marked by cycles of recovery, relapse, and repeated treatment episodes.[16,17] This is particularly true for young adults.[18]

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

Evidence

In an exploratory study among individuals who entered but subsequently left publicly funded urban addiction treatment programs, authors found that 54% expressed unmet needs for social services, particularly in areas of job training, stable housing, and further assistance with housing.[19] Using data among community samples in abstinent recovery, researchers found that employment was the second most frequently mentioned priority at all stages of recovery.[20] Initiatives from SAMHSA have yielded valuable knowledge about the typology and implementation of recovery support services. For example, the Recovery Community Services Program was a SAMHSA-funded initiative consistent with a social-ecological framework; it includes sober and stress management, building constructive family and social relationships, peer coaching and mentoring, and education and skills training (including help with housing), as well as enhancing access to system-level resources such as primary and behavioral care, child welfare, and criminal justice systems.[21]

Although there is empirical evidence to support formal professionally directed aftercare models in reducing SUD among adolescents and young adults,[22,23] informal peer-based social network support also contributes to "recovery communities."[24] In a randomized trial of volunteer recovery support for adolescents after residential treatment discharge, researchers found better engagement in recovery management activities, including sobriety-related activities and self-help, and increases in the number of prorecovery persons surrounding the recovering individuals.[25] In another observational study, researchers found improvement in employment status was associated with SUD posttreatment recovery outcomes, including abstinence and reduced days missed from work due to substance use.[26] This adds to the literature primarily based on trials and systematic reviews about the link between employment and recovery outcomes.[27–30] Authors of a review study found a moderate level of evidence that recovery housing is associated with improvements in functioning, including employment and criminal activity, and abstinence.[31] Younger members participating in a substance abuse recovery housing intervention for ≥6 months experienced better outcomes in terms of substance use, self-regulation, and employment.[32]

For young adults, recovery support provided within the education setting, specifically, can be an important source of social support. Structured educational recovery support services have been growing in high school and college settings since the 1970s. There is substantial heterogeneity in the structure of recovery high schools and collegiate recovery programs, but the commonality is that both create environments to support relationships among peers with similar recovery goals. Recovery high schools are typically small programs embedded within another school or part of a set of alternative schools.[33] The schools provide academic courses that are often self-paced, as well as therapeutic support, which generally includes individual therapy and support groups. In a quasi-experimental study, adolescents with SUDs who attended a recovery high school experienced an increased likelihood of abstinence, compared with those who did not.[34]

Collegiate recovery programs facilitate social support for college students in recovery but tend not to provide separate educational experiences.[35] Services range from sponsoring on-campus mutual help meetings to structured programs that include a physical space where counseling and social events are hosted. There are no studies evaluating outcomes associated with these programs, but a survey of student experiences found that students were primarily motivated to participate in a college recovery program because of a need for a supportive peer network.[36]

Practice Considerations

There is general consensus that young adults with SUD require developmentally appropriate approaches for treatment and recovery.[37,38] Although factors vary in influencing relapse and recovery (including addiction severity, individual motivation and skills, co-occurring mental health conditions, family environment, and the availability of supportive peers), formal inpatient adolescent and young adult treatment programs tend to be short, lasting between 1 and 3 months.[39] When the treatment ends, young adults return to their communities often unprepared for the competing demands of social

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integration.[40] Therefore, practitioners should recognize that regardless of the levels of care the patient needs (be they early intervention services or intensive, inpatient medical care), young adults' recovery is influenced by many individual-, family-, and community-level factors. Practitioners should work with young adults to adopt a patient-centered approach to care that addresses the physical, psychological, interpersonal, and community factors that affect relapse and recovery.

Principle 2: The Workforce for Addiction Services for Young Adults Benefits From the Inclusion of Individuals With Lived Experience in Addiction

Guidance

In addition to evidence supporting the benefit of comprehensive recovery support services, evidence suggests there may also be benefits to having peer workers in the workforce to support youth recovering from drug abuse.[41] Typically, support recovery services provided by those with lived experience in addiction do not replace the need for formal treatment or clinical guidance; rather, they offer an enhancement to treatment that increases the likelihood of sustained recovery. Peers with lived experience can provide support to substance-using persons by sharing experiences and knowledge, offering understanding, and suggesting coping strategies. Personal, lived experience allows the peer recovery support provider to be "experientially credentialed"[41] and infuses interactions with a sense of mutuality designed to promote connection and hope.[42] Often, peer workers with lived experience in addiction are well positioned to motivate patients to cope with their challenges and engage more fully in skills training, employment, and social integration.[43]

Peer workers may work on a volunteer basis or be paid. When compensation is involved, the pay can vary widely.[44] Peers work in a variety of settings, ranging from recovery community organizations in which educational, advocacy, and sober social activities are organized, to churches or other faith-based institutions, to recovery residences, the criminal justice system, drug courts, health service centers, and addiction and mental health treatment agencies.[45] The function of the peer recovery support often matches the vision and mission of the individual settings and the needs of the community. The peer workforce has been shown to be a key component of the community reinforcement approach and has demonstrated valuable social roles in helping youth with drug abuse achieve recovery and maintain abstinence.[46,47]

Evidence

White[41] defined "peer-based recovery support" as the process of giving and receiving nonprofessional, nonclinical assistance to achieve long-term recovery. Other similar terminologies are used in the literature to describe peer-related support and contexts, including peer support, peer support group, peer provider, and peer mentor.[42,43] Extensive literature has shown peer support groups as a key component of existing addiction treatment and recovery approaches, including residential and sober living, 12-step programs, and treatment programs in community settings. Sober living houses are drug-free living environments for a group of peers to live and recover, and they rely on mutual sobriety support and participation. In a randomized trial, researchers found an Oxford House intervention (a self-run community in which residents are expected to contribute, work, and pay bills) was associated with a significant decrease in substance use after discharge from inpatient treatment, as compared to a usual-care condition.[48] Twelve-step programs such as Alcoholics Anonymous are the most popular peer support recovery approach held outside the formal treatment setting for addiction.[49] Alcoholics Anonymous affiliation has been linked to better self-efficacy, healthy coping, and reductions in alcohol and drug use.[50,51]

Peer support services within treatment and community settings vary substantially in modalities of delivery, including in-person self-help groups, peer-run or operated services, peer partnerships, peer specialists, case managers, advocates in health care settings, and Internet support groups.[52] Authors of 2 review studies found that active engagement in peer support groups has shown to be a key predictor of treatment retention, improved relationships with treatment providers, social support, and reduced relapse rates.[53,54] Methodologic limitations include small sample sizes, absence of appropriate comparison groups, and the inability to disentangle the effects of peer recovery support from other treatment and support activities. More rigorous investigations are needed to assess the effectiveness of peer support recovery programs, with special attention to the advantages of peer support integration within the substance use treatment continuum.

Practice Considerations

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

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

Principle 3: Recovery Support Services Should Be Integrated to Promote Recovery Most Effectively and Provide the Strongest Possible Social Support

Guidance

The goal of integrated care is to enhance the quality of care and quality of life, patient satisfaction, and system efficiency for those with complex, long-term problems across multiple services, providers, and settings.[55] In the context of young adult recovery support services, integration of services can be thought of as a means of delivering health and social support services by coordinating the efforts of services to respond more efficiently and effectively to the complex needs of youth with SUDs. Integration of care should go beyond coordination between formal treatment services (ie, detoxification and residential rehabilitation) to ensure greater continuity of care occurring between systems of formal treatment and recovery support services that reflect individual patient's needs and community resources. Typically, concerted methods and models on funding, administrative and organizational, service delivery, and clinical levels are needed to create and maintain integrated services. Clinicians who treat young adults with SUDs are in a unique position to gather frontline data on SUDs among young adults. They can use a screening tool to assess health-related social needs, work closely with case managers to develop a patient-centered care plan, and refer patients to social services. Clinicians can be strong advocates for colocated services, staff training, and information sharing. Hospitals and health centers can promote partnerships between their institutes and social services entities, share common agency goals, and promote interdepartmental collaboration.[56]

Evidence

There is growing evidence that health care and other social services can be integrated into treating and supporting patients with SUDs. There is success in integrating harm reduction strategies such as naloxone training and medication treatment to reduce SUD harms.[57,58] In systematic reviews, authors generally report that clients receiving integrated care with both SUD and mental health counseling demonstrate improved SUD and mental health outcomes (at least when mental health conditions are not severe).[59] Reviews of studies on patients with severe mental health conditions, however, have revealed inconsistent results.[60,61]

With respect to integrating SUD and support services, authors of a pragmatic clinical trial of coordinated care management found that clients who received integrated care used more social services and demonstrate greater abstinence rates as compared with standard care clients.[62] In a meta-analysis of integrating maternal substance use treatment and pregnancy, parenting, or child services, authors found reduced substance use associated with integrated care.[63] Among a small longitudinal cohort of homeless youth suffering from a first episode of addiction in Canada, an intensive outreach intervention integrating access to housing support organizations, mental health services, and collaborative learning among providers was effective in improving youth's housing stability, functioning, and illness severity.[64] Recent review studies also reveal the value of emerging interventions integrating recovery support services to include skills training,[65] employment and placement,[26,66] and budgetary services.[67]

Practice Considerations

Because complex health-related social needs are common among patients with SUD, case management is a common and practical model of service delivery for integrated care.[68,69] Case management can be intensive and often requires a long-term commitment, which may limit the ability of case managers to accept new clients. Pooling resources from community-based agencies to coordinate services offerings, match with client needs, and enhance referral systems may overcome constraints of case management.

One major obstacle to integration is organizational boundaries. Using a survey of 270 agencies offering services for women with addiction problems, researchers found that strong interagency relationships contributed to the success of integration.[70] Whereas formal interagency relationships help define accountability, informal relationships through the development of professional networks and collaborative learning opportunities can foster knowledge sharing around a common purpose.

At a clinical level, screening for health-related social needs enables the identification of the need for support services, although such screening tends to focus on the general population. In addition to the approaches of bringing the Screening, Brief Intervention, and Referral to Treatment paradigm into a pediatric medical setting and further integrating substance use counseling

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TABLE 1 Summary of Selected Studies Reviewed by Expert Panel

Content Area	Author, y	Sample	Study Period	Intervention	Design	Outcome	Main Findings	Contribution to Summit Principles
Housing	Jason et al[48] 2006	N = 150 with substance use history in an urban setting	24-mo study period with baseline and interviews every 6 mo	Either an Oxford House or usual aftercare condition (ie, outpatient treatment or self-help groups) after they had received inpatient treatment of substance abuse	RCT	Substance use; criminal activities; employment status	Oxford House condition participants had significantly lower substance use (31% vs 65%), significantly higher monthly income ($989 vs $440), and significantly lower incarceration rates (3% vs 9%) than usual-care participants.	Rigorous RCT that reveals the effect of mutual help-oriented recovery housing in reducing substance use and crime activities and improving employment for people with substance use history
Social services	Morgenstern et al,[62] 2009	N = 421 welfare applicants identified via SUD screen in a large city	Baseline, 1-, 3-, 6-, and 12-mo follow-up interviews	Randomly assigned to CCM involving various social services and coordinated referral system versus usual care	Practical clinical trial	Social services use; abstinence status	Broad and significantly more services use (eg, addiction, mental health, employment, and basic needs) and significantly higher rate of abstinence (OR: 1.75; 95% CI: 1.12–2.76; d = 0.31) were found among the CCM group as compared with the usual-care group.	A practical clinical trial revealing significant uptake of recovery support services and abstinence increase as a result of a coordinated system integrating social services with substance abuse treatment
Peer support	Bassuk et al,[54] 2016	N = 9 studies	English literature of primary empirical quantitative studies 1998–2014	US studies in PubMed, PsycInfo, and Web of Science with the following search terms: peer involvement; alcohol or drug addiction; peer-led recovery interventions	Systematic review	Substance use (primary outcome); service use, mental health, criminal justice status, and quality of life	Despite limited evidence involving strong methodologic rigor, peer support was found to be beneficial and associated with improved recovery outcomes and reduced substance use.	Extensive review study summarizing evidence of peer support recovery in reducing substance use and other recovery-related outcomes, with extensive recommendations for strengthening further studies on peer-delivered recovery support services
Volunteer support	Godley et al,[25] 2019	N = 402 youth aged 12–20 and discharged from residential treatment	Assessed over 12 mo postdischarge	Randomly assigned to either 9 mo of posttreatment VRSA or continuing care services as usual	RCT	Prorecovery peers, recovery management activities, substance use, and remission	VRSA participants had greater increases in drug-free sobriety activities (d = 0.21), substance abuse treatment (d = 0.31), and self-help activities (d = 0.30), indicating that they engaged in more mutual aid group activities and continuing care treatment than standard care participants.	Rigorous trial involving a large sample and revealing improvements in both proximal (prorecovery activities) and distal outcomes (reduced substance use)
CM	Vanderplasschen et al,[69] 2019	N = 31 studies	English literature January, 2006 to May, 2017	Embase, Web of Science, Medline (PubMed), the Cochrane Drugs and Alcohol Group Specialized Register and Cochrane Central	Review meta-analysis	Treatment-related outcomes; personal functioning outcomes	CM is more effective than treatment as usual conditions for improving outcomes (SMD 0.18; 95% CI: 0.07–0.28), but this effect is significantly larger for	Meta-analysis on a large No. trial studies providing a rigorous synthesis of the effect of CM for integrated support services

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TABLE 1 Continued

Content Area	Author, y	Sample	Study Period	Intervention	Design	Outcome	Main Findings	Contribution to Summit Principles
				Register of Controlled Trials			treatment-related tasks (SMD 0.33; 95% CI: 0.18–0.48) than for personal functioning outcomes (SMD 0.06; 95% CI: 0.02–0.15).	

CCM, coordinated care management; CI, confidence interval; CM, case management; *d*, Cohen's *d*; OR, odds ratio; RCT, randomized controlled trial; SMD, standardized mean difference; VRSA, Volunteer Recovery Support for Adolescents.

and brief interventions into school and college settings,[71] providing screening for health-related social needs may help maximize the accessibility of comprehensive and integrated support services for youth with SUDs.

There is an increased use of mHealth technology to support substance use recovery among youth.[72,73] Given the ubiquity of mobile phone use and improved engagement among young adults, more evaluation is needed to assess practical feasibility and effectiveness of using mobile technology to provide integrated services and enhance uptake of potentiating timely and needed interventions to promote support and recovery among young adults.

CONCLUSIONS

In light of multiple and complex needs for youth recovering from SUDs, it is critical to enhance recovery support services, including peer workers, with features that aim for experiential credibility. It is also critical to integrate these recovery services for young adults into existing treatment structures and community resources. Table 1 summarizes select evidence from rigorous studies that support a comprehensive array of recovery support services. Although the principles in this article derive from the research literature that may tend to focus on the general population or on a certain type of substance (ie, alcohol) and not necessarily on opioid use among young adults, these principles should serve as a useful guiding roadmap for overcoming barriers and achieving better efficiency and quality of care.

ABBREVIATIONS

SAMHSA: Substance Abuse and Mental Health Services Administration
SUD: substance use disorder

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