Substance Use Disorder Transition Age Youth

Peer Delivered Services - Best Practices Curriculum

The Regional Facilitation Center

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Acknowledgements:

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

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

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Introduction

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

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

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

Classroom Directions

This text is designed for in-class training.

1. Review and discuss a Best Practice.
2. Ask each participant to complete the associated self-assessment. The self-assessment check box can also be used as an "agency self-assessment" check box.
3. In groups, have participants discuss their strengths and areas needing improvement based on their self-assessment.
4. Facilitate a class discussion around the insights gained by individuals through self-assessment and group discussions.
5. Move on to the next Best Practice and repeat the process.

Methodology

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

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

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

Literature Review and SME DACUM Workgroup

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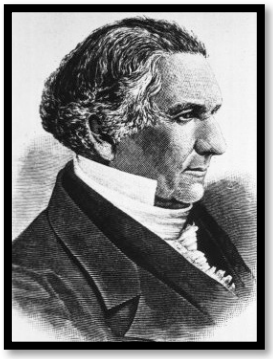
SUD Transition Age Youth Peer Delivered Services Best Practice Curriculum

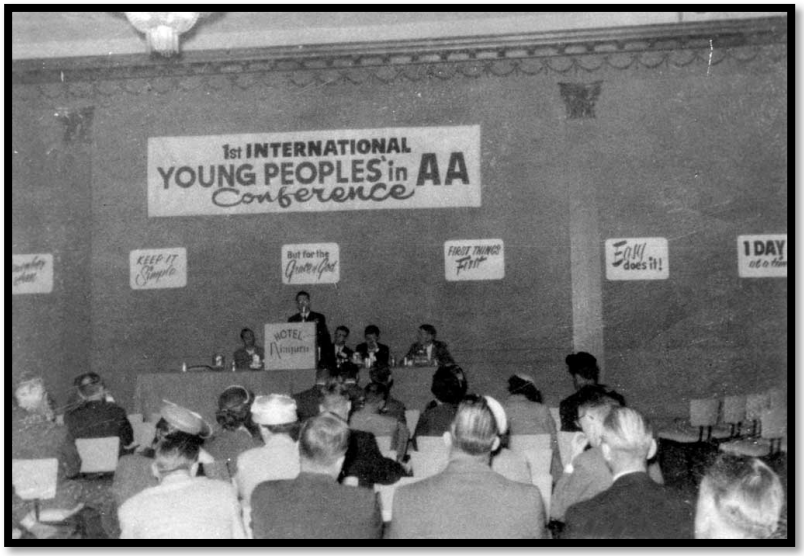
Forward: A Brief History of Youth Addiction Peer Recovery



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

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

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



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

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

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

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

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

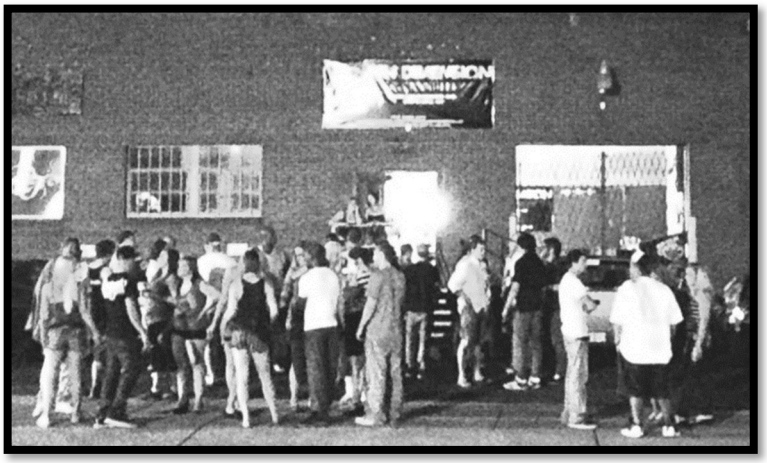
In 2011, Young People in Recovery (YPR) was founded as a youth-focused advocacy organization. The organization currently produces youth peer delivered curriculums, including EPIC and Phoenix.

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

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

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

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



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

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

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

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

Section One: Building TAY Peer Delivered Services

☑ Best Practice One: SUD Peer Services Created, Directed, and Delivered by Youth.

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

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

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

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

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

Examples of peer youth branding:

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

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

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

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

Section Two: SUD Youth Recovery Community

☑ Best Practice Four: Building Youth Social & Recovery Communities.

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

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

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

☑ Best Practice Five: Facilitating Event/Activity-Based Recovery.

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

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

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

☑ Best Practice Six: *Use of Technology in the Recovery Community.*

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

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

Review of Recovery Apps

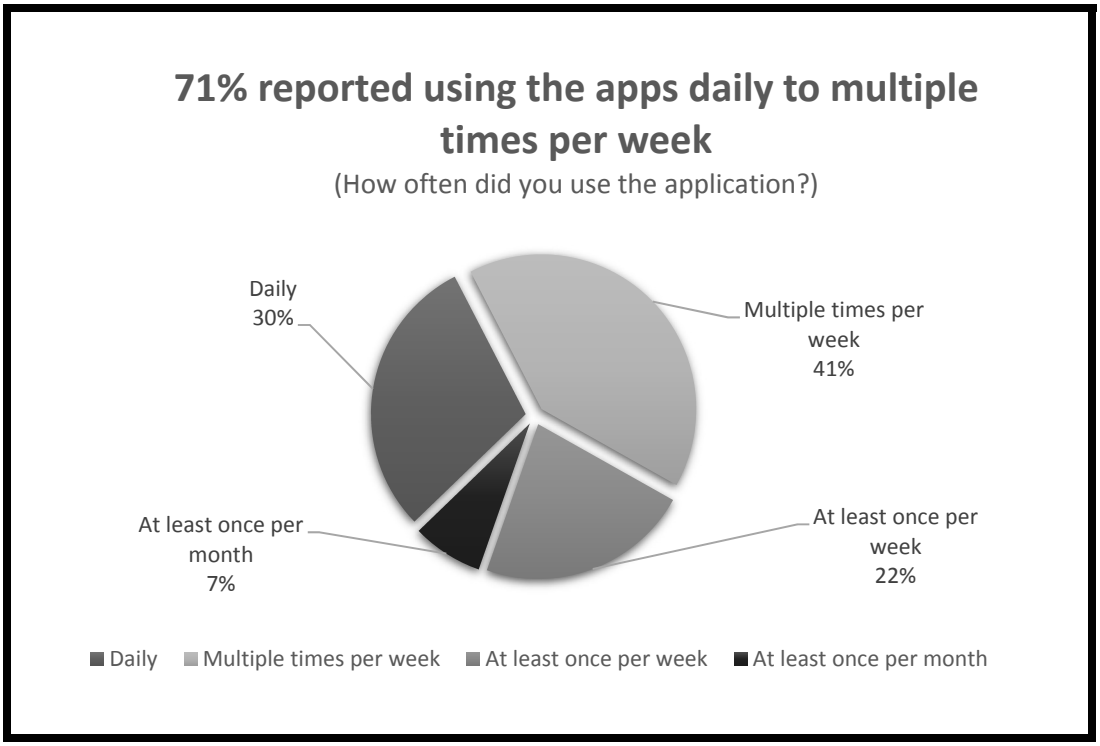
As a part of this best practices curriculum, we conducted a qualitative review of several "Recovery Apps" that contain social connectivity. These "Recovery Apps" focus on four major components:

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

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

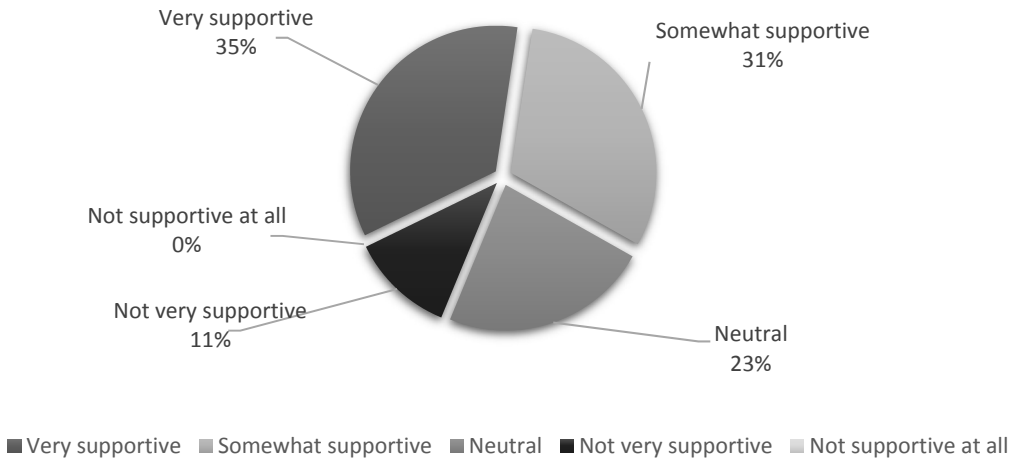
- A-CHESS
- Sober Grid
- A Recovery Facebook Group
- Squirrel Recovery

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



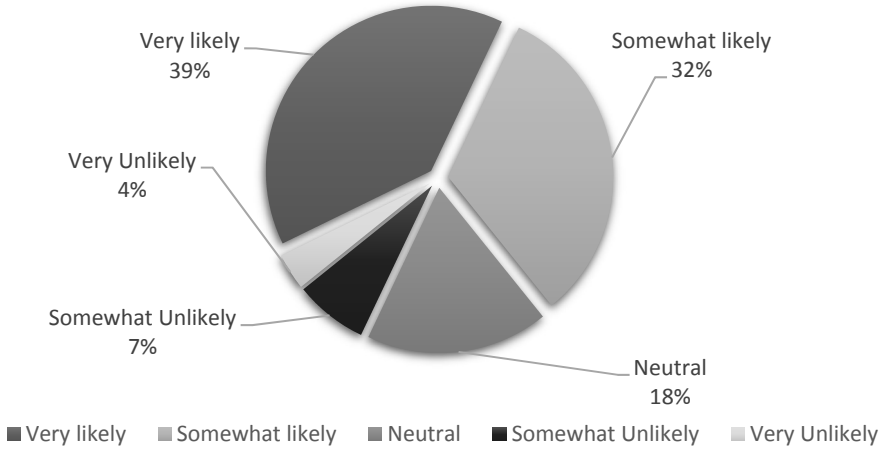
66% felt the apps were very or somewhat supportive of their recovery

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



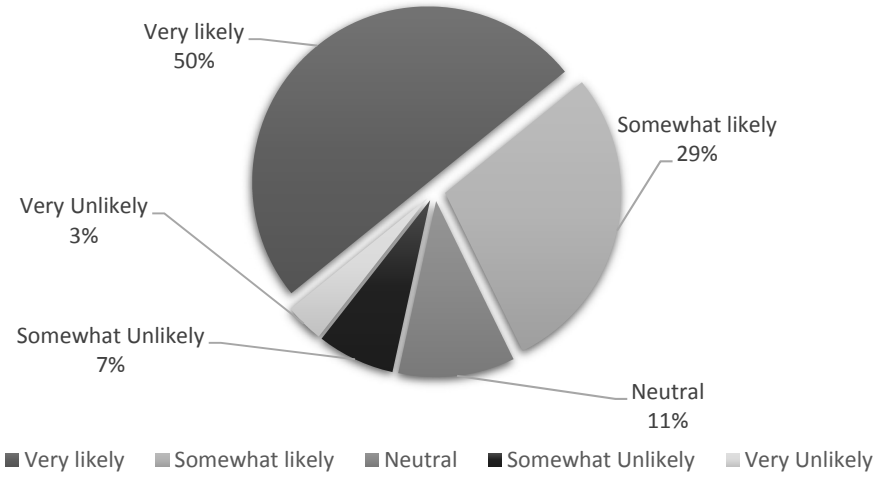
71% reported they are very likely to somewhat likely to continue using the apps

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



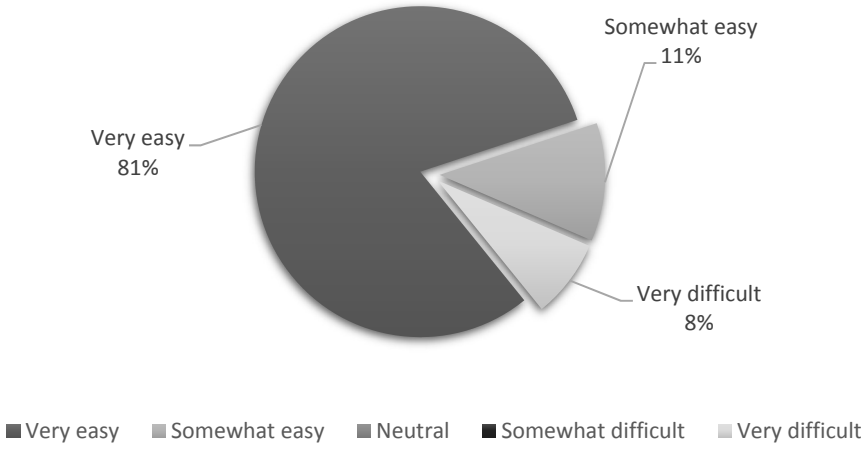
79% reported they are very likely or somewhat likely to refer other youth to the app

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



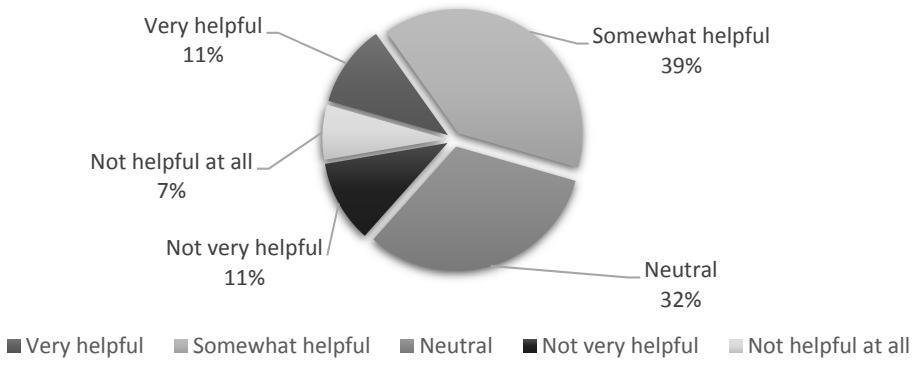
92% reported that the apps are very easy to somewhat easy to use

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



50% reported the apps are very to somewhat helpful in reducing cravings

(On a scale of 1-5 how helpful was this app in reducing cravings?)



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

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

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

Summary

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

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

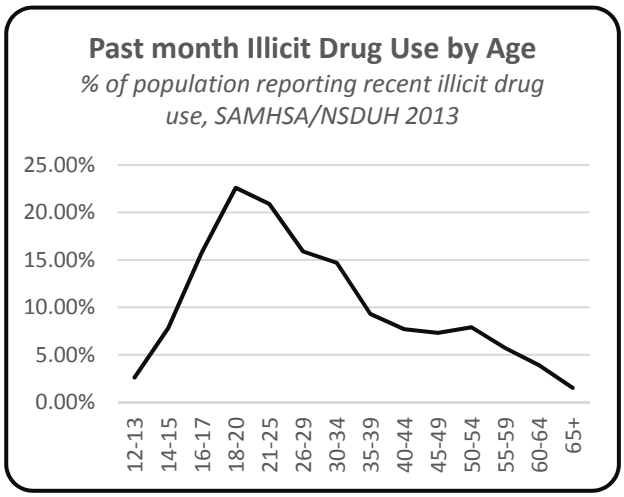
Recovery apps are sure to evolve and adapt over time, will continue to be a part of the youth recovery movement and will need to address a lack of immediate responsiveness/support for individuals in crisis. Youth peer programs endeavor to build recovery communities. Similarly, building an active ever-present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

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

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

Section Three: SUD Youth Peer Services

☑ **Best Practice Seven: Screening Transition Age Youth for SUD Peer Services.** Screening youth for appropriateness of services is an important aspect of SUD youth peer programs. For example, 18-20 year old's have the highest rate of substance use and many experience emotionally-driven episodes of excessive substance use that would not necessarily meet the diagnostic criteria for a severe substance use disorder (addiction). SUD youth peer programs are dedicated to addiction recovery, and must be able to screen participants to maintain their primary mission and purpose of striving towards abstinence (Ridenour et al., 2012). Many allied behavioral health professionals have a difficult time understanding the distinction between episodic emotionally-driven substance use, and chronic addiction often driven by tolerance and withdrawal.



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

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

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

Type of Youth Program	Target youth group	Goal of services
Youth Mental Health Peer programs	• Youth with mental and emotional challenges who present episodic or occasional excessive alcohol and/or drug use. • Their use of drugs and alcohol is largely driven by emotions, and is more episodic vs. chronic, with little to no prior attempts to quit or cut down.	Strive to reduce, contain, or stop substance use and self-medication of mental and emotional difficulties, oftentimes focusing on the emotions that fuel excessive substance use.
Youth Addiction Peer programs	• Youth addicted to alcohol and/or drugs, who have chronic use, and meet the diagnostic criteria for a severe substance use disorder. • History of early onset use (Van Ryzin & Dishion, 2014). • Their substance use is driven largely by craving, tolerance and withdrawal, and is more chronic vs. episodic, with numerous prior attempts to quit or cut down. • These individuals chronically use substances without regard to their emotional states (happy, sad, joyful, depressed, angry, content, etc.).	Strive to abstain from alcohol and illicit substances and develop coping skills to avoid relapse.

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

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

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

4th Dimension Recovery Center

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

Screening questions

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

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

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

Self-Assessment Checklist ✓	
Best Practice #8: Embrace Diversity, Inclusivity & Individuality through the Primary Mission	
☐	Youth peers understand the diversity of the youth participating in the program.
☐	Peer staff understand the wide range of peer services (resources, support, linkages, etc.) needed for individuals with varying amounts of recovery capital.
☐	Challenges inherent with inclusivity are overcome by maintaining focus on the primary mission of SUD recovery. The singularity of purpose (addiction recovery by any means necessary) binds diverse individuals together in common cause. Alternative pathways and styles of recovery are expected and respected. Youth peers are encouraged to respect multiple pathways and styles of recovery initiation and maintenance.
☐	Peer programs develop policies to ensure the safety of diverse individuals. For example, "no hate speech," "no financial exploitation of those with financial resources," or "no sexual exploitation of those with little to no resources."
☐	Peer programs incorporate continued training and education specific to various diverse populations: LGTBQ2I, gender identity, race and ethnicity, disabilities, etc.

☑ Best Practice Nine: Person-centered and Trauma-informed Care.

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

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

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

☑ Best Practice Ten: Intensive Contact Post-treatment.

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

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

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

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

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

☑ Best Practice Twelve: Employment, Education & Housing.

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

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

☑ Best Practice Thirteen: System Navigation: Supporting the Inexperienced.

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

Self-Assessment Checklist ✓	
Best Practice #13: System Navigation: Supporting the Inexperienced	
☐	Youth peers orient individuals to various systems and let them know what to expect in the process (criminal justice, child welfare, health care/Medicaid, colleges, vocational training, TANF, SNAP, housing agencies, addiction treatment, mental health, etc.). Where many adults may have prior experiences with systems, feeling frustrated or forgotten, many young people have no experience with these systems what-so-ever. Youth peers incorporate "orientation to systems" into systems navigation by assisting individuals in setting up appointments, accompanying individuals to appointments, and filling out paperwork.
☐	Youth peers engage and advocate for individuals within systems to ensure that they fully understand those systems, receive appropriate services, are treated fairly and that they voice any questions, concerns or objections they may have. Youth peers empower individuals through a three-step process: • Step One: It's OK to ask questions • Step Two: It's OK to express your concerns • Step Three: It's OK to voice your objections
☐	Youth peer staff can often be less educated in system navigation themselves due to their own lack of experience. Programs prioritize resources and system navigation during supervision to ensure the staff achieve systems literacy.
☐	Youth peers convey the individual's point of view when working with colleagues (SAMHSA, IC&RC: Peer Competencies).
☐	Youth peers partner with community members and organizations to strengthen opportunities for the individuals they serve (SAMHSA, IC&RC: Peer Competencies).

☑ Best Practice Fourteen: Boundaries & Role Ambiguity Inherent in TAY Peer Services.

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

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

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

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

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

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

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

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Appendix 1

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

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

Likert Validation Survey

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

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

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

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

Appendix 2

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

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

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

4th Dimension Recovery Center Social Media/Electronic Communication: Informed Consent & Release

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

Peer Service Participant Name:
DOB or Social Security:
Date:

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

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

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

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

Release:

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

    ☐"Yes, I would like a copy of this form."

Please initial all elements of communications that you agree to

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

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

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

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

SIGNATURES CERTIFYING APPROVAL FOR TWO-WAY RELEASE OF INFORMATION:

Signature of Peer Program Participant Date

Signature of Parent/Guardian Date

Signature of Witness or Agent Authorized for Releasing Information Date