Alternative Peer Group: A Model for Youth Recovery

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Alternative Peer Group: A Model for Youth Recovery

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Adolescent and young-adult drug and alcohol use rates continue to hold steady and the research on effective long-term treatment models is sparse. During the past 40 years, a recovery community for adolescents and young adults has formed in Houston, TX, that provides comprehensive treatment services for families struggling with this issue. The purpose of this article is to describe the history and model of the adolescent peer group, its place in the recovery-oriented systems of care (Kaplan, 2008) as a chronic-care approach, and implications for future research in social influence, recovery capital, and long-term treatment for recovering youth.

KEYWORDS adolescents, young adults, recovery, outpatient, model

Adolescent brains are more vulnerable than are mature adult brains to the effects of alcohol and drug abuse (Brown et al., 2009). Those who delay use until age 21 or older are 6.5 times less likely to develop a substance use disorder (National Center on Addiction and Substance Abuse at Columbia University, 2011; U.S. Department of Health and Human Services, 2007). Unfortunately, the rates of adolescent and young-adult drug and alcohol use have held steady in recent years with the use of some substances such as marijuana increasing (Centers for Disease Control and Prevention, 2010; Johnston, O’Malley, Bachman, & Schulenberg, 2011). According to a 2010...
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A survey completed by the Substance Abuse and Mental Health Services Administration (SAMHSA), of the 2.6 million U.S. citizens who received specialized treatment for a substance abuse problem, an estimated 676,000 were aged 12 to 24 years old (National Institute on Drug Abuse, 2010). For these reasons, treating and preventing further youth alcohol and substance use is of vital importance.

However, many current treatment methods for youth are based on modified adult models despite significant differences between the adolescent and adult populations (Dasinger, Shane, & Martinovich, 2004; Sussman, 2011). Compared with adult substance users, adolescent substance users are less likely to present for treatment, are more likely to have a co-occurring mental illness, and relapse more quickly after treatment (Sussman, Skara, & Ames, 2008). Further, Ramo and Brown (2008) documented that adolescents were far more likely to relapse when experiencing social pressure compared with adults, at rates of 70% and 46%, respectively. Potential reasons for these differences might lie in the differential development of certain brain regions that govern reward and cognitive control systems during adolescence (Casey, Jones, & Somerville, 2011). Casey et al. (2011) suggest that the subcortical brain regions controlling sensation and reward-seeking behavior mature during adolescence, while the prefrontal cortical regions that regulate inhibition and cognitive processes lag behind and reach full development in adulthood. In addition, adolescent risk taking is far more likely than risk taking of adults to occur in groups due to neurobiological changes that lead to an increase in the salience of peer relations during adolescence (Steinberg, 2008).

KEY FACTORS FOR EFFECTIVE ADOLESCENT TREATMENT

The aforementioned differences have been the impetus for much investigation regarding how specifically to tailor treatment for youth. Previous researchers have discovered certain elements or key factors that should be included for effective treatment of alcohol or substance use problems that are specific to adolescent populations (Brannigan, Schackman, Falco, & Millman, 2004; Godley, Godley, Dennis, Funk, & Passetti, 2002; Kelly, Myers, & Brown, 2005; SAMHSA, 2010a). Moreover, Brannigan et al. (2004) identified nine key elements of effective adolescent substance abuse treatment programs. Highlighted among these are longer lengths of stay, parental involvement, aftercare participation, and positive social support within a climate of trust. These findings are consistent with other research indicating increases in effectiveness with the use of comprehensive approaches that deal with all aspects of a youth’s life (Godley et al., 2002; Sussman et al., 2008). In addition, Godley et al. (2002) recommended that adolescent treatment episodes include sufficient intensity and duration, provide problem-solving skills training, focus on relapse prevention, and increase prosocial leisure activities.
Another significant factor in adolescent and young-adult treatment is that of social influence. The benefit of affirmative social influence is evidenced by the increased positive substance abuse outcomes for youth who participate in 12-step groups of youth of similar ages (Kelly et al., 2005). However, adolescent attendance at 12-step meetings is often low and drops off significantly within a brief period of time following discharge from treatment (Chi, Kaskutas, Sterling, Campbell, & Weisner, 2009; Kelly & Myers, 2007; Kelly et al., 2005). This might be due to the fact that the average age of people in Alcoholics Anonymous (AA), for example, is 49 years old and that youth are not finding connections with others of a similar age (Alcoholics Anonymous World Services, 2012). This demonstrates the importance of utilizing the social influence of similar-aged peer support to increase positive outcomes for youth in recovery.

THE ALTERNATIVE PEER GROUP MODEL

The alternative peer group (APG) model utilizes social influence and incorporates key factors for developmentally appropriate and effective adolescent treatment (Cates & Cummings, 2003; Meehan, 1984; Rochat et al., 2011). What follows is a description of the model, its theoretical underpinnings, and details regarding how the key elements of effective adolescent treatment are integrated into the model. A discussion regarding how the model fits into the existing recovery support services (RSSs) is provided followed by an account of the model’s history. The rich history of this model outlines the replication and growth of the APGs in Houston, TX. This account might serve as an example of how to build a recovery community tailored to the adolescent and young-adult population, thereby providing an opportunity for increasing positive outcomes in youth recovering from substance abuse.

An APG offers an adolescent a new group of friends that provide alternative attitudes, values, judgments, processes, and behavior that support the change necessary to recover from substance abuse disorders (Binarium Productions, 2011). The APG model of substance abuse recovery services has been used with adolescents and young adults. It includes 12-step meetings, counseling (individual, family, and group), multifamily group, and psychosocial education for youth and parents. Most importantly, the foundation of the APG is the social component (Cates & Cummings, 2003; Meehan, 1984). Namely, social functions include afterschool hangouts, sober social weekend activities, and retreats. The hallmark of this model is the basic assumption that peer relationships, much like the ones that initiate and support drug and alcohol use, are necessary to facilitate recovery (Morrison & Bailey, 2011; Rochat et al., 2011). Figure 1 graphically depicts the elements that comprise an APG program.

As is the case for other programs with peer-led interactive components, a potential limitation of the APG model is unanticipated iatrogenic effects.
FIGURE 1 Diagram of Alternative Peer Group Depicting the Alternative Peer Group Elements (color figure available online).

(Valente et al., 2007). Programs that utilize the social influence of peers run the risk for exposure to negative as well as positive influences. However, the strong effect that friends have on adolescent risk behaviors serves as a persuasive argument in favor of APGs that focus on developing positive peer pressure (Maxwell, 2002). Valente et al. (2007) note that “social interaction is safe when norms favor non-use of illicit substances, but must be carefully tailored and monitored when norms favor use of illicit substances” (p. 1813). The APG model includes youth staff members who shape sober norms by facilitating peer-led groups and activities as well as professional staff members who carefully monitor individual behavior and group structure. The effects of this combination and other outcomes warrant future empirical exploration of the APG model.

To date, APG participants have been the focus of only one study conducted by the physician assistant program at Baylor College of Medicine (Rochat et al., 2011). These researchers evaluated the perceived attachment to parents of 114 adolescents enrolled in an APG compared with 127 students from a local high school. Results from this study suggest that adolescents enrolled in an APG perceive greater attachment to and experience improved communication and trust with their parents compared with control group participants. Parents of adolescents enrolled in APGs were surveyed during this study and reported that the program helped improve their relationships with their children and other family members. In addition, these parents reported that the programs taught them how to set effective boundaries and support their adolescents in recovery.
THEORETICAL UNDERPINNINGS

The theoretical framework upon which the APG model was built includes: (a) 12-step principles, (b) social influence, and (c) recovery capital (AA, 2001; Cloud & Granfield, 2008; Kelman, 1958). Bob Meehan, the founder of the original APG Palmer Drug Abuse Program (PDAP) in Houston, TX, was a recovering alcoholic, addict, and ex-convict who based his adolescent program on the 12 steps (Meehan, 1984). He received permission from the World Service Organization of Alcoholics Anonymous to alter the wording of the steps to be "more suitable to people dependent on mind-changing chemicals in general, not just alcohol" (Meehan, 1984, pp. 121–122; see also PDAP, n.d.). Adding more inclusive language to the 12 steps enabled adolescents to relate to and connect with others regardless of which substances they had used. As an RSS, 12-step meetings have been documented to be effective, and youth who attend these meetings have significantly better substance use outcomes (Davidson et al., 2010; Kelly et al., 2005; Passetti & White, 2007; SAMSHA, 2010b). Thus, the 12-step model is an essential construct without which abstinence outcomes would be significantly lower (Chi et al., 2009; Kelly et al., 2005; Morral, McCaffrey, & Ridgeway, 2004). However, Meehan knew that making the steps more appealing was not what was changing the hearts and the minds of the youth he counseled. Although he might have not been aware of it then, he was utilizing the principles of social influence theory, which holds that attitude and behavior change can occur through the influence of other people (Kelman, 1958).

The social influence of adolescent peers can have a strong effect on the reduction of a variety of risk behaviors (Maxwell, 2002). Programs specifically geared toward adolescent recovery often utilize social influence theory, which demonstrates significant efficacy in preventing substance abuse by giving youth an alternative, abstinence-focused peer group (Boisvert, Martin, Grosek, & Clarie, 2008; Davidson et al., 2010; Engle, Macgowen, Wagner, & Amrhein, 2010; Morral et al., 2004). Within an APG, group facilitators and staff encourage and reinforce abstinence from substances and recovery-oriented behaviors. At first, these changes might occur out of compliance. As the youth becomes involved in the group, opportunities to identify with others increase and potentially lead to internalization. Kelman (1958) describes internalization as a process resulting in intrinsically rewarding behavior change that aligns with the individual's existing value system. Youth with more time in the APG who have achieved such change model healthy, sober behaviors and exert positive peer pressure on newcomers who might eventually become new leaders who repeat the process.

A valuable social network develops as these recovering youth build relationships within the APG and ultimately venture outside the peer group and participate in RSSs within the greater recovery community. As their recovery community grows, so too does their recovery capital (Davidson et al.,
Much of a youth’s ability to stop misusing substances relates to the environmental context in which they are situated including what personal characteristics and resources are available to them (Cloud & Granfield, 2008). Recovery capital is defined as “the quantity and quality of internal and external resources to initiate and maintain recovery” (Davidson et al., 2010, p. 391). In other words, recovery capital refers to the host of factors that range anywhere from a person’s internal motivation for recovery to external elements, such as parental, educational, or peer support. For many youth who live in families struggling with divorce, addiction, and relationship problems, recovery capital grows in the form of a sense of belonging as the youth engages in new, supportive relationships. During a life stage, when rates of substance use among same-aged peers increase and abstainers are difficult to find, this recovery capital strengthens and extends the benefits of treatment for youth within this new recovery support system (Kelly, Dow, Yeterian, & Kahler, 2010).

THE ROLE OF THE APG MODEL IN RECOVERY-ORIENTED SYSTEMS OF CARE

An APG is an RSS specifically tailored for adolescents that aligns with the values and principles of a recovery-oriented system. SAMHSA and the Center for Substance Abuse Treatment have led the treatment field in a movement from an acute care model to a chronic care approach known as recovery-oriented systems of care or (ROSC; Kaplan, 2008; White, 2002). Within an ROSC, RSSs seek to increase a person’s recovery capital by providing a full range of human services to individuals prior to, in conjunction with, and after treatment (Davidson et al., 2010). As an RSS, the APG adheres to the following ROSC values and principles: (a) accessible services that engage and retain people seeking recovery, (b) a continuum of services rather than crisis-oriented care, (c) age-appropriate and culturally competent care, and (d) care in the person’s community using natural supports (Kaplan, 2008).

The APG model also offers a continuum of care that specifically meets the chronic care needs of youth substance misusers. Spear and Skala (1995) observed that 42% of adolescents and young adults relapse within 30 days of discharging from treatment. Other researchers have found that 64% of adolescents return to using within 3 months, 70% within 6 months, and 77% by 1 year following their discharge from treatment (Brown, Vik, & Creamer, 1989; Winters, Stinchfield, Opland, Weller, & Latimer, 2000). These outcomes highlight a fundamental need to connect youth to long-term aftercare options such as an APG that can support recovery maintenance. Furthermore, the APG model provides age-appropriate care that heavily integrates and
utilizes natural supports available in the person’s community, such as recovery schools, community agencies, and where appropriate, recovery-oriented faith communities (Rochat et al., 2011).

HISTORY OF THE ALTERNATIVE PEER GROUP MODEL

The ROSC values and principles expressed in this article are reflected in the APG model, in that the APG model has grown and multiplied in the Houston, TX, community and has therefore allowed for increased accessibility. During the past 40 years, a recovery community for adolescents and young adults has formed in Houston that provides comprehensive RSSs for families who struggle with youth alcohol and drug problems. The community consists of a network of peer and professional RSSs including agencies, organizations, faith-based communities, and recovery schools working collaboratively to provide struggling young people with opportunities for recovery. Figure 2 represents the APG in relation to the local recovery community. It began in 1971 when a group of young people struggling with alcohol and drug

![Diagram of Alternative Peer Group Recovery Community Depicting the Alternative Peer Group in Relation to the Recovery Community (color figure available online).](image-url)
problems formed at Palmer Memorial Episcopal Church in Houston (Palmer Memorial Episcopal Church, 2012). Named the Palmer Drug Abuse Program (PDAP, n.d.), it was the first youth outpatient treatment model to combine sober social activities with 12-step meetings. This model became known as the APG and was replicated in different locations all over the city. Soon thereafter, PDAP opened satellites across the United States. Eventually, PDAP staff members began branching off to open their own versions of the APG model. Currently, there are five APGs in the greater Houston area for adolescents and young adults (APG, 2012; Cornerstone Recovery, 2009; Lifeway International, 2011; PDAP, n.d.; Teen and Family Services, 2012).

As the APGs grew, they began forming collaborative relationships with other adolescent and young-adult recovery agencies and organizations. Central figures among them include two recovery high schools established in 2003 and 2004 (Archway Academy, 2011; Lifeway International, 2011). One of these schools, Archway Academy, is located in Palmer Memorial Episcopal Church where PDAP obtained its start. Archway Academy is an official member of the Association of Recovery Schools (Association of Recovery Schools, 2006). To gain admission to Archway, a student must be an active member in one of the five local APGs. Sometimes students are referred to a recovery school after being admitted into an APG, and other times, students seek these services simultaneously.

Other agencies and organizations in the community began actively including APGs within their services or incorporating them into client aftercare plans. One such example is a local inpatient treatment center, which offers residential treatment services to adolescents and coordinates with the local APGs to organize on-site 12-step meetings for their clients (Memorial Herman Prevention & Recovery Center, 2005–2011). Introduction to the 12 steps through an APG allows sober social networking to begin prior to discharge from treatment and increases the youth’s chances of connecting to the recovery community. Another example of a supporting organization is a local nonprofit agency that provides meeting space to two of the APGs and hosts social events and dances for APGs and the recovery schools (The Council on Alcohol and Drugs Houston, 2012). In conjunction with the local APGs, this agency hosts symposia, continuing education, and training for APG staff members and clinicians who work with APG clients.

Included in the Houston recovery community are a number of churches that support APGs in a variety of ways. Many offer meeting space to APGs from low to no cost. Some provide recovery services to the same population. For example, one local church provides APG meeting space and is well known in the community for offering religious services tailored for people in recovery (Chapelwood United Methodist Church, 2012). The extent of church involvement in the philosophy and administration of APGs depends upon the specific values and beliefs of each individual APG. For some, a Christian influence is explicit, whereas others embrace individual spiritual beliefs.
All APGs, whether or not directly connected to a local church, encourage members to incorporate some type of spiritual practice into their lives. The original APG, the PDAP, promotes the use of the word *God* in their edited version of the 12 steps: “sought through prayer and meditation to improve our conscious contact with our Higher Power, that we have chosen to call God, praying only for knowledge of His Will for us and courage to carry that out” (Meehan, 1984, p. 134). Other APGs choose to utilize the original 12 steps and emphasize the discovery of a higher power of one’s own understanding.

**KEY FACTORS PRESENT IN THE APG MODEL**

The APG model tailors treatment for youth from a chronic care approach that encompasses the values and principles of a recovery-oriented system. Building on the research of Brannigan et al. (2004), we have sought to identify which key elements of effective adolescent substance abuse treatment are present in the APG model. Brannigan et al. identified nine key elements in the effective treatment of adolescents and young adults with substance abuse. These key elements are present in the APG model despite often being incorporated through trial and error or intuition, rather than through systematic adoption based on research. Nonetheless, the current trends in research offer validation that these elements are critical constructs in the replication, growth, and sustainability of the APG model. These elements include assessment and treatment matching, a comprehensive integrated treatment approach, family involvement in treatment, developmentally appropriate programming, engagement and retention of adolescents and young adults in treatment, qualified staff, gender and cultural competence, continuing care, and treatment outcomes. In addition to these elements, Godley et al. (2002) outlined key components of successful posttreatment programming for adolescents who were also present in the APG model. These elements included increasing prosocial leisure habits, offering sufficient intensity and duration of contact, focusing on relapse prevention, and providing problem-solving skills training.

In addition, the APG model is well suited for collaborating with RSSs within the greater recovery community such as recovery schools. The Houston APG community provides an excellent example of how APGs can connect youth to recovery by increasing accessibility and attendance in recovery schools. Recovery high schools have become a growing part of the movement to support sustainability in adolescent recovery (Finch, 2007; Finch & White, 2006). Approximately 22 years ago, the first recovery high schools began in the United States (Vogel, 2009). After a decade, 6 recovery schools had been established, and today, it is estimated that close to 35 recovery schools exist throughout the country (Vogel, 2009). In a 2007 study, Moberg and
Finch reported that attendance in recovery high schools reduces students’ substance abuse and mental health symptoms. In addition to recovery high schools, collegiate recovery programs have become a growing component in the young-adult recovery movement since the advent of the first on-campus recovery support in 1977 at Rutgers University (Finch, 2007; Finch & White, 2006; Harris, Baker, Kimball, & Shumway, 2007). Currently, the Association of Recovery Schools lists 26 recovery high schools and 17 universities in the United States hosting collegiate recovery programs (Association of Recovery Schools, 2006). APGs serve as a bridge to these programs encouraging students to attend recovery high schools and continue maintaining their sobriety by gaining admission into a college that offers programs to support their recovery.

CONCLUSION

Although several treatment modalities exist for adolescent substance abuse and dependence, many are modified versions of adult models and fail to include long-term aftercare components (Dasinger et al., 2004; Sussman, 2011). There is a paucity of research regarding models for adolescent and young-adult substance abuse treatment and aftercare. The current article is the first to describe an adolescent and young-adult recovery community that encompasses the APG treatment model designed specifically to address long-term care for adolescent and young-adult substance users.

In Houston, the APG model grew out of a grassroots, highly localized, community movement that, over time, remained open to the incorporation of new elements of holistic RSSs. The APG model started with the cultivation of age-specific and developmentally appropriate 12-step interventions and quickly grew to include family support, professional counseling, faith-based communities, and other local support agencies and organizations. PDAP, in 1971, preceded the inception of any other known APG and was geared specifically to support youth recovery. However, the evolution of the current model has taken the last 40 years to develop into the comprehensive system it is now.

Today, the APGs remain a central tenet in the supportive structure of the youth recovery community in Houston. The APG provides sufficient intensity and duration of aftercare outpatient treatment, significant family education and involvement, positive peer relationships, prosocial leisure activities, and a multitude of additional supportive factors (Rochat et al., 2011). The information presented in this article suggests the APG model has played a key role in the formation, growth, and maintenance of the adolescent and young-adult recovery community in Houston, TX. However, to date, no study has examined the factors that contributed to the growth and sustainability of this community, and only one study has attempted to investigate the factors relating to local APG outcomes (Rochat et al., 2011).
The APG model has important implications for clinicians, treatment providers, educators, and communities seeking to assist their youth in recovering from substance abuse and warrants further study. Future research should include studies of outcomes for youth involved in the APG model, which would allow for comparison of the APG model against that of current standard adolescent treatments. Specifically of interest will be understanding the effects of social influence on youth in an APG as well as the effects of long-term, comprehensive care that emphasizes strengthening of recovery capital. Based on the findings from outcome data regarding efficacy of the APG model, there are implications for the replication of this chronic-care approach for recovering youth in other cities (Rochat et al., 2011). Due to the highly localized, grassroots nature of the APG model in Houston, others seeking to replicate this model would be wise to organize key stakeholders in the community to take part in the formation of an APG. These key stakeholders might include educators, clinicians, community leaders, helping professionals, community agencies, and faith-based communities that could work collaboratively to create an APG within a recovery-oriented system of care for youth and their families seeking recovery.

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