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'Pickle or a cucumber?' administrator and practitioner views of successful adolescent recovery

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Abstract

Introduction—Adolescent substance use disorders often involve a recurring cycle of treatment and relapse. The academic and practical definition of *addiction recovery* for adults has been debated; yet, elements determining a successful adolescent recovery aside from abstinence have not been delineated. Thus, we sought to explore how practitioners and administrators define “success” in recovery and how they foster youth progress towards success.

Methods—Using a qualitative design, we purposively selected and visited treatment and recovery services sites and interviewed practitioners and administrators (N = 13). Sites included recovery high schools (N = 2), alternative peer groups (N = 4), and one treatment center. Two authors analyzed the data using the constant comparative method.

Results—Success emerged from the interviews in three primary themes (1) factors demonstrating success, (2) progress that highlights success, and (3) factors enabling success and two sub-themes (1) use of metaphors and (2) use of specific examples. A variety of factors and processes were discussed as indicators of success. Multiple practitioners stated that sobriety and length of abstinence were not the best success measures; yet, sobriety and education were mentioned most often.

Conclusions—A key finding of this study, which has not been addressed in existing qualitative studies of youth recovery, is that the understanding of recovery was so diverse and multi-dimensional and provided a view of success beyond sobriety, highlighting the various facets from which practitioners must operate and address recovery. This demonstrates the need for researchers to carefully conceptualize how they operationalize adolescent recovery.

Introduction

Substance abuse and dependence can severely impact one's quality of life and opportunities. This appears especially true for adolescents: substance use disorders (SUDs) can negatively impact the developing brain, reducing one's capacity to grow to his/her full potential (Macleod et al., 2004; Squeglia, Jacobus, & Tapert, 2009; Vo, Schacht, Mintzer, & Fishman, 2014); hinder efforts to do well in or finish school which reduces later employment opportunities (Anderson, Ramo, Cummins, & Brown, 2010); and can damage relationships with family, peers, and others (Hibbert & Best, 2011; Menasco & Blair, 2014; Skogens & von Greif, 2014). Receiving and completing treatment for SUDs is one first step towards recovery from addiction; however, research has shown that treatment receipt is only one step

in a cyclical process with some adolescents engaged in problematic substance use through multiple relapse and treatment episodes (Cornelius et al., 2003; Spear, Ciesla, & Skala, 1999).

Although once primarily focused on adults, the treatment and continuing care system has greatly expanded to address adolescent-specific needs (Sussman, 2010). Indeed, today there are adolescent treatment and continuing care programs and even schools and collegiate recovery communities for youth in recovery (Fisher, 2014; Moberg & Finch, 2007). For example, recovery high schools (RHS) are schools meeting state requirements for awarding a secondary diploma with a primary purpose of educating youth in recovery (Association of Recovery Schools, 2016, p. 20). To meet these goals, RHSs only serve recovering youth and combine therapeutic recovery services, such as counseling, with academic programming (Moberg & Finch, 2007). Alternatively, recovery supports such as alternative peer groups (APGs) seek to provide recovering youth with a structured and sober social environment (Collier, Hilliker, & Onwuegbuzie, 2014). The social component of APGs, primarily achieved through afterschool and weekend hangouts is the foundation of the model; however, APGs also offer counseling, psychosocial education, multi-family group meetings, and 12-step meetings.

The process of adolescent recovery is considered different from adult recovery (Ciesla, Valle, & Spear, 2008; Deas, Riggs, Langenbucher, Goldman, & Brown, 2000): adolescents are younger than adults meaning that their substance use history is likely much shorter, and developmentally, different aspects of treatment are important to adolescents compared to adults. Although our title stems from the research interviews reported in this article, the idea that an adolescent with a SUD “may be sitting in the vinegar” but could still be a cucumber or a pickle when it comes to substance use, is not novel. For example, authors have argued that adolescent recovery from a SUD may not completely align with the 12-Step model, i.e., that of “abstinence for life”: there is a possibility that an adolescent could eventually responsibly use legal substances without the consequences they experienced during their problem episodes (Bonomo & Bowes, 2001; Canadian Paediatric Society, 2008).

In the context of addiction literature and scholarship, however, how is the term *recovery* defined? In William White’s *Addiction Recovery Glossary*, recovery is defined as follows:

Recovery is the experience of a meaningful, productive life within the limits imposed by a history of addiction to alcohol and/or other drugs... ‘Recovery’ implies that something once possessed and then lost is reacquired. The term recovery promises the ability to get back what one once had and as such holds out unspoken hope for a return of lost health, lost esteem, lost relationships, and lost financial or social status. (2002, p. 29).

Similarly, the Betty Ford Panel, a panel convened to decide the working definition of recovery, determined that recovery is “a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship” (2007, p. 222). The Substance Abuse and Mental Health Services Administration (SAMHSA) described recovery as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (2011, p. 3). These broad definitions suggest that multiple

factors indicate successful recovery, and qualitative research with adults in recovery supports this assertion (Best, Gow, Taylor, Knox, & White, 2011; Kaskutas et al., 2014; Laudet, 2007). That is, although sobriety appears at the center of recovery, adults have previously highlighted that recovery is a process and success goes beyond abstinence (Best et al., 2011; Laudet, 2007). Indeed, Kaskutas and colleagues (2014) found four unique domains of recovery among adults, only one of which was sobriety. The other domains included factors such as self-care, personal growth, dealing with challenging situations, and demonstrating caring for others, all elements unique from abstinence, but identified as important to sustaining recovery as well as being indicators of recovery.

In light of these slightly different academic definitions of recovery and previous explorations of adult recovery experiences, it remains important to understand how those who are in direct contact with adolescents using treatment or recovery supports, typically adults, view and discuss success in recovery. This is especially salient given that how adult practitioners and administrators in these programs conceptualize recovery may influence how they approach their work, including the specific activities and conversations they engage in with their clients. Exploring the definition of success among this particular sample might enable a better understanding of how practitioners support youth progress towards successful recovery. In addition, because practitioner approaches can affect youth engagement in recovery, findings of this study may also be important for understanding better ways to approach and study recovery processes among youth.

Study Aim

This study explored the concept of adolescent success in recovery among practitioners and administrators of youth treatment and recovery supports. Thus, the guiding research questions in this exploratory study are as follows: (1) How do practitioners and administrators working with adolescents in recovery from a SUD view *success* in the program; (2) What are the components of a *successful* recovery?

Method

This study used a qualitative approach, composed of site visits, semi-structured interviews, and the constant comparative (Corbin & Strauss, 2008) and domain analysis (Spradley, 1979) methods to inform the findings.

Participants

Purposive sampling methods were used to conduct information-rich interviews with adult administrative and therapeutic staff members who worked with adolescent clients of recovery high schools (RHSs), treatment centers, and alternative peer groups (APGs). The adolescent clients were recruited for a larger study, an examination of the effectiveness of RHSs in three states in the United States, and they are not included in this report (see *removed for blind review*). The current project includes a sample of adult practitioners (N = 13) who were cooperating with the larger study and recruited from participating treatment and continuing care sites and RHSs. Although the Institutional Review Board (IRB) at our primary site granted approval for the larger study, the IRB considered the interviews with

staff members at recruitment sites reported in this article to be exempt. All interview participants were given an information sheet and informed that their participation was voluntary.

Data Instruments and Collection

Prior to site visits, semi-structured interview guides were created. The project's Principal Investigators created these guides over a period of several weeks through discussion. The guides were based on the previous research experience of the investigators, which included use of similar interview protocols (e.g., see *removed for blinded review*), existing literature, and the aims of the larger study. The questions in the guide addressed multiple aspects of the program, including program administration, staff experience, responsibilities, and perspectives on recovery, and day-to-day operations. The interview guide questions varied slightly by site to capture differences in roles and activities, based on the type of site. For examples of questions used at treatment centers, see Appendix A.

Data collection involved a visit to seven different sites (one treatment center, two RHSs, and four APGs) in one state (April, 2014). Site visits lasted approximately 1–2 hours. At each site, semi-structured interviews were conducted with at least one administrator and/or one staff member. All participants were asked the same questions from the guide specific to their site type. Probing questions, based on interviewee responses, were also asked. Based on site preferences, some simultaneous interviews with multiple staff members were conducted. Interviews were audio-recorded with the permission of the individual and detailed notes were taken. When available, at least two research team members were present in each interview.

Data analysis

After interviews were transcribed and data were de-identified, the first and second authors of this article analyzed transcripts using the qualitative software, HyperRESEARCH (Researchware, Inc., 2013). The software was used as an organizing tool so that each investigator could independently electronically capture themes for later comparison and discussion. The analysis was driven by the constant comparative method as described by Corbin and Strauss (2008): with the goal to “discern conceptual similarities, to refine the discriminative power of categories, and to discover patterns” (Tesch, 1990, pg. 96). This process allowed the findings to emerge from the data. The initial process included open coding whereby authors created a preliminary codebook for use in HyperRESEARCH based on one reading of each transcript and the guiding research questions. Given our position as researchers and the potential for researcher bias around our own ideas of how *success* would be revealed in the interviews (Onwuegbuzie, & Leech, 2007), we sought to enhance the trustworthiness of our work. Thus, we conducted two activities recommended by Lincoln and Guba (1985): investigator triangulation through double coding and negative case analysis. Through double coding, memo writing, and discussions, we worked to challenge our incoming assumptions. Throughout coding we also engaged in negative case analysis by looking for success outside of our traditional views of success. For example, we noticed that although an interviewee might discuss success in very positive terms, there were often sections of the interview where adolescents were referred to as “lost” or “stagnated”.

Situated against the idea of success, these instances appeared in direct contradiction, but also seemed to highlight what the interviewee felt was decidedly not success. Thus, success could be evidenced by very positive demonstrations of behaviors as well as a lack of certain behaviors or engagement in negative behaviors.

The initial version of the codebook included the following primary codes: (1) population of youth served by the organization; (2) size of the organization (such as number of sites, number of youth attending, number of staff employed); (3) position of interviewee in the organization; (4) training/experience of the interviewee in the organization (as it relates to SUD treatment and recovery); and (5) instances where success of youth participants is discussed by interviewees (broadly or by using specific examples). The first four types of codes were used to capture information from the programs (1–2) and the interviewees (3–4) to the coding of instances of success. The final code, *success*, was used to identify areas of the interviews directly relevant to the primary research questions.

Using the first version of the codebook, three transcripts were individually reread and coded and coding memos were written. Discrepancies were then discussed and consensus was reached to identify pattern regularities. Modifications to the codebook were then made to increase clarity. The first and second authors of this article used this process of triangulating the information to individually code the remaining transcripts. All disagreements were resolved through consensus. Thus, this first round of coding was primarily used to identify sections that addressed demographic and programmatic information and instances of success.

Once instances of success had been identified through the coding process of all interviews, the coding process involved a constant evaluation of information from each interview to refine categories within *success*: that is, we used domain analysis (Spradley, 1979) to determine properties and dimensions of success in the data. The purpose was to assess whether *success* occurs as thematically different across the interviews and/or if some common themes about how *success* is discussed emerge. Through this process, we agreed to add five preliminary codes to the codebook as categories of *success* and recoded the selected excerpts using three primary categories (1) factors demonstrating success, (2) progress or development that highlights success, and (3) factors enabling success and two sub-categories (1) use of metaphors and (2) use of specific cases or examples to discuss success. In reviewing the interviews, we found that interviewees used the two sub-categories to discuss the three major categories of success; that is, the two sub-categories in every instance overlapped almost entirely with the three primary categories of success and thus are incorporated into the discussion of each primary category in the results section. In addition, although our primary interest was in success as the outcome, an understanding of what respondents termed “failures” or “unsuccessful” emerged as potential explanations to success in recovery: these excerpts were subsequently coded as *negative instances* and have been included as appropriate within the primary categories.

Results

The site visits rendered eight transcripts with seven unique sites. We interviewed multiple participants at some sites resulting in interviews with a total of 13 program staff with a diverse set of background training and experiences (Table 1). Although the majority of staff were program administrators, they also remained involved in the therapeutic aspects of the program and most had worked as practitioners with adolescents for years.

Factors Demonstrating Success

Throughout the interviews, participants highlighted multiple factors as demonstrations of positive outcomes including the following: sobriety, staying engaged in the recovery process, learning and using life skills, returning to school, and entering post-secondary education. Additionally, participants discussed adolescents becoming emotionally healthy: “I think, for me, what I care about the most is an adolescent being able to create a life that they really want and an adolescent being able to look in the mirror and love what they see looking back at them” (APG3, R4). However, educational and sobriety outcomes were most often mentioned during interviews. For example, the concept of being productive in either school or work was discussed by multiple participants: “Productive means they’re in school fulltime or part-time in school, working part-time. They’ve got a full-time job. They’re in graduate school fulltime.” (APG1). Other interviewees stressed the importance of finding post-high school goals relevant to adolescents’ own interests:

My other goal is just to have them set up where they have something that they can be excited and passionate about post-high school. So if that looks like cosmetology school or to you know, doing an apprenticeship to be an electrician or do a vocational or technical school... (RHS1).

One example also highlighted how specific recovery factors demonstrate participant success. In this case, the (1) youth self-reported his relapse to substance use, (2) then started working the program, and (3) is three weeks sober.

... that happened with a kid here, C., he had a two or three relapses, he’d been in treatment for eighteen months, long time, and got out, relapsed... he was the one who, he would come in and tell us that he had relapsed, which makes it easier (laughs)... then he just started digging in and really working the program. You know he has three weeks now I mean and he’s doing the deal. (RHS2).

Other speakers used metaphors to discuss this process. Although one participant spoke about what he thinks enables recovery, his metaphor of “stick with winners” is also an insight into what he thinks demonstrates successful recovery, that is, actual time in sobriety: “We, because we operate on a stick with winners approach, we felt like the best thing that could happen is they were involved with people that already have some time in sobriety...” (APG4). Another example from an adult staff member (APG2) emphasized a multi-dimensional view of the process of success that may not entail life-long or full-time continuing care supports:

I’m not sure he is going to need the adult 12-step community the rest of his life... we discharged the kid to the football team. He switched high schools... [now] he’s

just graduating high school... and he's off to [university] without ongoing sorta adult 12-step support, he's done really, really well, you know. And so I think part of that philosophically was just getting away from that mindset where it's a pickle or a cucumber... so what I say is they may be sitting in the vinegar but that doesn't make 'em a pickle yet.

Although oftentimes the focus was on educational and sobriety outcomes, it was also clear from these interviews that adolescents need to demonstrate multiple indicators to establish success. These factors together support an overall picture of recovery:

And our goal is for them to be able to have at least three successful weekend passes at home and that they're motivated to maintain their sobriety. They're attending meetings on pass. They're engaged. They have an interest in their education so they're, you know, willing to go back to school. The work with the family has progressed... (TX CENTER, R1).

Participants also discussed negative outcomes, or factors that could demonstrate a lack of success, such as not graduating from the program or becoming detrimental to the health of the community because, according to one respondent, "... they no longer have a willingness or desire to live a chemical-free life" (APG3, R1). One participant discussed individuals they track after program completion. She stated that while most of their former youth clients were living "productive" lives, there were also a small proportion "that are stagnated or out drinking or doing drugs." (APG1). So, although *factors used to demonstrate success* is a very robust category and related to varying elements in an adolescent's life, when interviewees used specific factors to demonstrate the opposite of success, they mainly discussed sobriety. This emphasizes program staff aligning with a primary focus on sobriety in recovery.

In these interviews there was also a focus on developing a healthy life overall and what that might look like. For example, through the use of a metaphor, one participant emphasized the importance of thinking holistically about what participants need to be successful, and that sobriety, is only one "drop" of many needed steps: "But part of what's different is we are not focused just on sobriety. We want 'em to get sober but that's such a drop in the bucket to what these kids need." (APG1). Later, she used the metaphor of dodging a bullet to refer to what negative outcomes could occur if the treatment program is unsuccessful in enabling recovery:

Each kid who actually really recovers and becomes a productive citizen, I mean there you've got like a, you've dodged so many bullets in healthcare costs and STD's and unwanted pregnancies and automobile accidents and, you know, theft and prison sentences. (APG1).

Lifelong sobriety was not always paramount for an individual to be and to remain a successful case: "If somebody's successful, I don't care if they're drinking. I don't care what they're doing" (APG1). However, emphasizing the importance of sobriety with youth was seen as necessary for initiating early recovery: "...but if you say, well, you might be a social drinker later... Then you've messed with their idea of what they need to, you know, they they're just deferring their drinking instead of grasping recovery" (APG1). Indeed, other participants indicated that sobriety is important to achieving initial recovery success, but

once an adolescent is able to maintain other aspects of their lives, complete abstinence may not be necessary. For example, the participant from APG2 stated:

I've always said that simply measuring length of abstinence is a terrible measure about loss and success. I think they're, at some point somebody's gonna really open up and look at global functioning. Because... if a kid comes in and gets three months sober and then uses for a month but comes back in, but they were using every day, and school improves, family life improves then you know based on sobriety or not sobriety that would look like a failure, but it's a terrible measure.

Hence, this data points to the importance of the category of progress that demonstrates success. Success is often viewed by staff members from a holistic standpoint and compared to where that person is in their life relative to where they were before.

Progress Towards Success

Progress towards success captures instances when interviewees used an adolescent's progress in their recovery or within their specific program to link it to success. Although it is similar to *demonstrating success*, in the *demonstrate* category the factors are more concrete and measurable while *progress toward success* involves changes witnessed by practitioners over time.

Interviewees discussed progress in different ways. For example, some referenced progress in relation to time off of drugs and what was possible based on how the brain was recovering:

But that first six months, they are, you know, go over there right now, there are six, I think, holes punched in the walls and, you know, the kids are just such a mess that, you know, they're emotionally too volatile to be able to really focus, get their cognition in charge at that level. (APG1).

Others discussed this progress in relation to time spent engaging in the program and to eventually buying in to the process. Two staff of a treatment center emphasized this point:

"None of them are here willingly. They sometimes say they're willing, but then they get here and they change their mind." (R1)

"Yeah." (R2)

"No, they're not. But they, you know, they become engaged." (R1)

One of the RHS staff also mentioned adolescents not being engaged in the beginning of their transition to a new school environment:

... what I seem to see, is more often that not within the first month, thirty days, it's a relapse... They get caught. There's, you know, response, there are consequences, and you know, and in a sense I believe because the student is able to remain in the school... it's sorta like, okay well what do you do now, you know? Like they're not gonna kick me out... they're making adjustments, maybe the kid starts IOP, maybe the kid starts individual sessions, whatever that looks like. And then most of the time they'll start to dig in and they'll start to use the groups and they'll you know really start their kinda path of recovery. (RHS2).

Thus, for some individuals, success was also related to initial relapses and the ability for the adolescent to learn from mistakes in a supported environment. Success was not about being perfect in one's recovery, but owning mistakes when they happened and working with staff to get to the next step: "... we know they're gonna have relapses, we know they're gonna make mistakes, but as long as they stay engaged in recovery, then being successful will come." (APG2). Success also meant that the adolescents would not need to remain in the program forever: "... the other thing we started working with was how and when to say to somebody, you are done with needing this staff, that you can move on..." (APG4).

Factors Enabling Success

Participants discussed factors that enabled successful outcomes: these factors were individual (internal to youth such as learning life skills), interindividual (such as family involvement and being around other peers in recovery), as well as directly tied to aspects of individual programs (such as accountability and consistent recovery supports).

Building individual capacity was considered paramount to successful recovery. Participants discussed building capacity in multiple ways, but most often mentioned building life skills and self-confidence, recognizing the need to enable adolescents to develop into mature adults. For example, one APG leader (APG3) stated:

... we're also doing, developing self-esteem, you know, developing confidence, helping them through the, all the adolescent awkwardness as far as who they are, that independence, you know, trusting their peers, the emotional development, helping them with that. So everything that we do as a program even though the focus is on sobriety, in reality for them getting to sobriety, is working with all these other at-risk behaviors and aspects of development...

Participants also discussed enabling factors to avoid later relapse: their programming addressed future planning to meet a particular adolescent's needs and strengths. For example, one RHS participant felt that "...we just need to be in the planning stages with them of their junior and senior year, cause the biggest triggers for relapse will be boredom and feeling like they don't have any purpose." (RHS1). Another participant, from APG2 thought about it in terms of

... looking at it from the perspective of what are these kids really going to need to be successful in college? It's not just, how to go to meetings and how to get a sponsor and how to stay sober. I mean they have no idea how to study. They have no idea how to really manage a lot of things that they're gonna need. Stress management.

Another participant also discussed how she viewed the program and her own role in enabling successful recovery in metaphor terminology:

I see this as being a seed. You know we're here to plant a seed. You know, what is it that's gonna help the seed grow? If I can help, showing them where the water is, where the fertilizer is, where the rich soil is, then that helps them to grow and bloom, then I agree. (APG3, R1)

Additionally, many participants stressed the importance of family involvement and including parent programming and, at some events, mandating parent involvement. For example, staff from two APGs mentioned: “Kids whose parents took a leadership role in the parent group who, you know, began to really volunteer their time to do some of the planning and support the group, those were the kids that did well” (APG1). Another APG staff member (APG3, R4) stated that “... if the whole family doesn’t get well, then the teenager usually doesn’t have a very successful experience.”

Respondents also discussed the importance of education in returning to mainstream society and the importance of school in this process, especially a school incorporating recovery. One APG interviewee (APG1) stated: “...education is just so important... So, yeah, we want them to be in school. We don’t want ‘em to go back to their old school and so we would prefer that everybody go to [recovery high school].” Similarly, one school interviewee (RHS2) felt that, “We have yet to, you know, hear a case of it being a good idea to return to a public school. We never advocate for that.”

Discussion

Despite the existence of adolescent-specific treatment, continuing care programs, and schools for adolescents in recovery (Fisher, 2014; Moberg & Finch, 2007), academic definitions of recovery differ. Therefore, it remains important to understand how practitioners, who are in daily contact with adolescents in treatment or recovery support services, view and discuss success in recovery. Thus, this study explored how administrators and practitioners working with adolescents in recovery from SUDs view success among their clients. A key finding of this study, which is also supported by research with adults in recovery (Best et al., 2011; Laudet, 2007), is that the understanding and view of recovery was so diverse and multi-dimensional that it provided a view of success beyond sobriety, highlighting the various facets from which practitioners must operate and view success. These results support recent suggestions to consider recovery as “a dynamic process characterized by increasingly stable remission resulting in and supported by increased recovery capital and enhanced quality of life”, a definition that does not necessarily require abstinence, but does focus more holistically on quality of life (Kelly & Hoepfner, 2014, p. 5).

A notable finding from previous work with adults suggests that individuals in recovery with more severe SUD histories were more likely to align with an abstinence-focused view of successful recovery (Kaskutas et al., 2014; Laudet, 2007). Given that adolescents likely have shorter and thus possibly less severe SUD histories than adults in recovery, it seems that practitioners recognize that lifelong abstinence may not be necessary for successful recovery, although initial abstinence certainly is. The following perspective (a quote introduced in the results) highlights this particular approach to recovery:

...he’s off to [university] without ongoing sorta adult 12-step support, he’s done really, really well, you know. And so I think part of that philosophically was just getting away from that mindset where it’s a pickle or a cucumber... so what I say is they may be sitting in the vinegar but that doesn’t make ‘em a pickle yet. (APG2).

With this quote, the practitioner highlights two potential ways to view adolescents in recovery: whether an adolescent is addicted to substances for his/her life (*pickle*) versus someone who is not always in recovery and could eventually safely use legal substances without the negative repercussions they currently face (*cucumber*). If one is a cucumber, ongoing abstinence may not be the best way to determine success in recovery. But if one is a pickle, it seems that abstinence would be the primary determining factor. For those working with developing adolescents, it may be too soon to tell whether they are a pickle or a cucumber. Perhaps that is why so many participants discussed multiple positive outcomes as evidence of success; other positive outcomes can provide evidence for quality of life post-program. This finding demonstrates the need for researchers to carefully conceptualize how they operationalize recovery, especially for an adolescent population. A binary indicator of relapse to use, what is often measured in recovery research, is simply not enough to understand success in the adolescent recovery process.

Limitations

A great degree of research experience from our diverse study team was involved in the creation of the semi-structured interview guide; however, it was created with the larger study's overarching purpose. It was not designed to focus on success, and although questions around success were asked and participants were probed for additional detail, the primary focus of the interview was to understand program-level data. A more extensive interview guide focused on success might elicit different or more nuanced responses. Focusing on a larger sample that included a wider range of adolescent practitioners in the treatment and recovery field may also have yielded a more diverse group of responses around success.

Additionally, although most of the interviewee responses indicate that lifetime abstinence is not necessarily the goal for success, these are all known as abstinence-based programs. Thus, overall, it appears that the interviewed practitioners consider abstinence as a means to success, if not the ultimate end for every adolescent. Their adolescent clients might be receiving mixed messages about what they are aiming for. However, we did not interview clients about how they felt their goals aligned with the practitioners with whom they worked or how this might impact their own recovery process; therefore, this is an area for future research to address.

Conclusions

The perspective of the practitioner on their views of successful program outcomes has rarely been explored. Yet, facilitators, therapists, and administrators are stakeholders whose daily livelihood is characterized by experiences and interactions with youth who are experiencing recovery. Given the results of the current study, further research with larger samples of administrative and therapeutic staff is warranted to inform the definition of success in the context of adolescent recovery. Further, researchers in their study of adolescent recovery would do well to consider the practitioner's definition of adolescent recovery as something more complex than sobriety in the last 30 days and create more nuanced operationalizations of adolescent successful recovery.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Program and Interviewee Information

Site Type	Program Size	Population of Youth Served	Interviewee position and description	
APG1	<ul style="list-style-type: none"> 150 families and 40 youth in intensive outpatient TX 4 program sites 	<ul style="list-style-type: none"> 14–17 years old 80% have multiple psychiatric diagnoses and are on multiple medications Wide SES range Mix of males and females Often have had TX Mostly white 	<p><i>President</i> “I’m sorta ultimately responsible for those, the treatment and the funding and the management of funds and, you know, sorta everything else... My role then has become more of clinical supervision, donor relationships, you know, advocating for the organization, oversight of the finances... But I do actually see clients as well as provide educational programs mostly for parents.”</p>	
APG2	<ul style="list-style-type: none"> 60 youth 3 program sites 	<ul style="list-style-type: none"> 60/40 (boys/girls) “early intervention”/ aftercare Middle/upper middle class Mostly white and Hispanic youth 	<p><i>Chief Executive Officer</i> “There’s much more administrative and management stuff in my day to day stuff. Although I keep about five or ten hours a week open to counsel and do groups because if not I kinda lose touch, that’s when I hang out with the kids honestly. And so, but you know it’s managing the clinical staff, it’s working directly with the Board of Directors, supervising the Director of Development, all of the stuff that an Executive Director at a non-profit would do.”</p>	
APG3	<ul style="list-style-type: none"> 5 program sites, 6 groups 150 at largest site, 20–80 at other sites (~325) 	<ul style="list-style-type: none"> 12–17 and 18–25 “very diverse” Prevention/intervention 	<p>1 Executive Director, Program Director</p> <p>2 Program coordinator, counselor</p> <p>3 Youth group coordinator</p> <p>4 Youth group coordinator, counselor intern</p> <p>5 Clinical lead, program coordinator</p> <p>6 Program coordinator, project manager, counselor</p>	
APG4	11 program sites	<ul style="list-style-type: none"> 13–18 and 17–25 Prevention/intervention 	<i>Chief Executive Officer</i>	
RHS1	115 students		<i>Executive Director</i>	
RHS2	32 students	<ul style="list-style-type: none"> Primary white Socioeconomically diverse 60% had residential TX 	<p><i>Director</i> “Day to day the bulk of my work has to do with behavioral health, recovery support, parent communication, all of that.”</p>	
TX Center	<ul style="list-style-type: none"> 44 beds inpatient TX 25–30 outpatient TX 	<ul style="list-style-type: none"> Racially and socioeconomically diverse High risk mental health population, often have had previous TX 	<p>1 Clinical Director</p> <p>“My role is over, primarily over all the clinical programs. And I oversee also all the development work”</p> <p>2 Executive Director</p> <p>“I do individual therapy. I do family therapy. I do, I’m the support system when we’re short with a group therapist... Make sure that I’m the point person in the community, do a lot of community networking, the daily</p>	

Site Type	Program Size	Population of Youth Served	Interviewee position and description
			function of running the “TX CENTER”, the finance but we do share roles in that.”

Notes. APG = Alternative Peer Group. TX = Treatment. RHS = Recovery High School.

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