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Collegiate Recovery Communities Programs: What do we know and what do we need to know?

Alexandre Laudet, Ph.D.,
National Development and Research Institutes, Inc

Kitty Harris, Ph.D.,
Texas Tech University

Thomas Kimball, Ph.D.,
Texas Tech University

Ken C. Winters, Ph.D., and
University of Minnesota

D. Paul Moberg, Ph.D.
University of Wisconsin

Abstract

As the broad construct of recovery increasingly guides addiction services and policy, federal agencies have called for the expansion of peer-driven recovery support services. The high prevalence of substance use and abuse in colleges and universities in the U.S. constitute a significant obstacle to pursuing an education for the unknown number of youths who have attained remission from substance use dependence. Collegiate Recovery Programs (CRPs) are an innovative and growing model of peer-driven recovery support delivered on college campuses. Although no systematic research has examined CRPs, available site-level records suggest encouraging outcomes: low relapse rates and above average academic achievement. The number of CRPs nationwide is growing, but there is a noticeable lack of data on the model, its students and their outcomes. We review the literature supporting the need for the expansion of CRPs, present information on the diversity of CRP services and outline key areas where research is needed.

Keywords

Recovery; college students; recovery support services; substance use disorder; addiction

As science is increasingly supporting the conceptualization of substance use disorders (SUD) as chronic conditions (Dennis, Scott, Funk, & Foss, 2005; McLellan, Lewis, O'Brien, & Kleber, 2000), the SUD field is gradually moving from the prevalent acute care service model to a continuum of care paradigm on par with that used for other chronic conditions such as diabetes or asthma. While chronic conditions cannot be cured, the symptoms can be arrested and the condition managed using a mix of professional and peer-driven services and supports supplemented with self-management, based on the individual's needs, resources and recovery stage. The widely used symptom management approach is effective in improving long-term outcomes for a range of chronic conditions, including asthma, cancer, diabetes, depression, and severe mental illness (Bodenheimer, Wagner, & Grumbach, 2002a;

Please address correspondence to Alexandre Laudet alexandrelaudet@gmail.com.

Bodenheimer, Wagner, & Grumbach, 2002b; Huber, 2005; Institute of Medicine, 2001; McLellan, McKay, Forman, Cacciola, & Kemp, 2005; Weisner & McLellan, 2004). In the addiction field, recovery support services (RSS) are a key component of the SUD continuum of care (Kaplan, 2008; Sheedy & Whitter, 2009; White, 2008; White, 2009). RSS can be delivered by professionals and/or by peers. Professionally-delivered RSS include intensive outpatient or residential treatment, typically followed by continuing care or aftercare - a stepped down course of services - a model that is heavily practiced and researched (McKay, 2001; McKay, 2009; McKay et al., 2009; McKay, Lynch, Shepard, & Pettinati, 2005). Also used are regular recovery management check-ups (RMC) and early re-intervention to monitor clients' status, minimize relapse risk and provide linkage to services after relapse to shorten the cycle (Scott, Dennis, & Foss, 2005; Scott, White, & Dennis, 2007).

The most innovative form of RSS is the growing menu of peer-based recovery support services. The President's National Drug Strategy, a document issued yearly through the White House Office of National Drug Control Policy (ONDCP), emphasizes the importance of promoting recovery, regardless of pathway, i.e., whether or not professional treatment is sought (ONDCP, 2011).The Strategy calls for the expansion of peer recovery support services across community-based settings and explicitly notes the importance of fostering the development of recovery supports in academic settings, a goal that it shares with the U.S. Department of Education as detailed in a recent monograph (Dickard, Downs, & Cavanaugh, 2011). This paper focuses on an innovative and growing model of campus-based recovery support services, the Collegiate Recovery Program (CRP). We summarize research that supports the need for such programs, present available information on CRPs, and conclude with areas where key research is needed to further the dissemination of CRPs, including a brief description of a recently NIH-funded research project.

High prevalence of substance use and substance use disorders in young people

Drug and alcohol use, abuse and dependence among young people remain high. Young adults (age 18–25) have higher rates of illicit drug use and substance use disorders (SUD) than other age groups (Substance Abuse and Mental Health Services Administration, Office of Applied Studies [SAMHSA OAS] 2008a). Importantly, SUD rates triple from 7% in adolescence (12–17) to 20% in young adulthood (18–25); alcohol use disorders (AUD) alone triple from 5.4% to 17.2% during that transitional stage (SAMHSA, 2008; 2009). In 2007, 21.1% of young adults, i.e., *6.9 million persons*, were classified as needing treatment for drug or alcohol problems (SAMHSA, 2009). Though fewer than 10% receive needed treatment, the numbers are considerable: 24% of the 1,817,557 admissions to US public SUD treatment in 2007 were 15–24 years old; 86.7% of these youth admissions were for drug problems (especially marijuana, hallucinogens and inhalants) alone or drugs *and* alcohol (SAMHSA OAS, 2009). These numbers exclude those getting treatment privately and in non-specialty settings (McGovern, Saunders, & Vakili, 2011); moreover, most who remit from SUD are believed to do so without help (Granfield & Cloud, 2001; National Institute on Alcohol Abuse and Alcoholism, 2009; Toneatto, Sobell, Sobell, & Rubel, 1999). Thus the number of youths with a former but not current SUD (i.e., “in recovery”) is likely much higher than public treatment admission data suggest.

Relapse rates and relapse risks among youths

Rigorous studies have identified a range of effective interventions for young people (Becker & Curry, 2008; Chung et al., 2003; Dennis et al., 2004; Hser et al., 2001; Kaminer & Godley, 2010; Waldron & Turner, 2008; Winters, Botzet, Fahnhorst, & Koskey, 2009; Winters, Stinchfield, Lee, & Latimer, 2008). However, as with adults (Anglin, Hser, &

Grella, 1997; Laudet, Stanick, & Sands, 2007), post-treatment relapse rates are high and many youths are treated multiple times (SAMHSA OAS, 2008b). First-year post-treatment relapse rates range from 60 to 79% (Brown, Tapert, Tate, & Abrantes, 2000; Brown, Vik, & Creamer, 1989; Chung, Maisto, Cornelius, & Martin, 2004; Chung, Maisto, Cornelius, Martin, & Jackson, 2005; Godley, Godley, Dennis, Funk, & Passetti, 2002); within five years, over 90% of treated youths return to substance use (Brown & Ramo, 2006; Chung et al., 2003; Winters, Stinchfield, Latimer, & Lee, 2007).

Stress, negative affect (e.g., depression), social situations, temptations to use (e.g., exposure to/availability of substances), and academic challenges, all highly prevalent in youths' daily context, constitute key relapse `triggers" for that age group (Baker & Harris, 2010; Brown et al., 2008; Cleveland & Harris, 2010; Gonzales, Anglin, Beattie, Ong, & Glik, 2012; Jaffe, 2002; Ramo, Anderson, Tate, & Brown, 2005; Svensson, 2000; Winters et al., 2008). The substance use status of *peers* is especially influential, predicting youths' substance use behavior (Cimini et al., 2009; Godley & Godley, 2011a; SAMHSA OAS, 2009; White, 2008) and help seeking (Caldeira et al., 2009).

College attendance is increasingly important to professional and financial success. Transitioning into adulthood and into college are both demanding, offering new freedoms, opportunities and responsibilities, with less structure and supervision (Wechsler & Nelson, 2008). For youths in SUD recovery, these normative challenges are compounded by the need to maintain sobriety (and academic performance) in an “abstinence-hostile environment” (Cleveland, Harris, & Wiebe, 2010; Wechsler, Davenport, Dowdall, Moeykens, & Castillo, 1994). The high prevalence of drug and alcohol use on college and university campuses (Hingson, Zha, & Weitzman, 2009; Knight et al., 2002; Wechsler & Nelson, 2008) makes college attendance a severe threat to sobriety (U.S. Department of Education Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention, 2010; Woodford, 2001) that must often be faced without one's established support network if living away from home (Bell et al., 2009). This can lead to isolation when `fitting in' is critical, and/or to yielding to peer pressure to use alcohol or drugs, both enhancing relapse risks (Harris, Baker, Kimball, & Shumway, 2008; Woodford, 2001).

Need for recovery support for college students

Post-treatment continuing support is essential to and effective at maintaining SUD treatment gains (Dennis & Scott, 2007; Godley, Dennis, Godley, & Funk, 2004; Godley et al., 2010; Institute of Medicine, 2005; McKay, 2009; SAMHSA Office of Communications, 2009; Weisner, Matzger, & Kaskutas, 2002; White, 2008). A menu of professionally and peer-delivered (e.g., recovery coaching) `recovery management' strategies exists *for adults* (Kaplan, 2008; McKay et al., 2009; Scott et al., 2005; White, 2009); combined, they constitute an emerging continuum of care consistent with chronic disease management. Less attention has been paid to understanding the need for a developmentally appropriate recovery support system for SUD adolescents and transition age youths than to their adult counterparts (Hser & Anglin, 2011). Research has shown that an acute clinical care model alone is insufficient to sustain youths' treatment gains and achieve long-term recovery (SAMHSA OAS, 2009). Although there are promising youth aftercare strategies (Godley & Godley, 2011b; Godley et al., 2010), *most young people do not access these resources* (SAMHSA Office of Communications, 2009): Only about a third receive professional aftercare (Godley, Godley, Dennis, Funk, & Passetti, 2007; McKay, 2001) and peer-based approaches (e.g., 12-step groups), while effective for youths have a high attrition. Often, the older age composition of meetings limits the potential for identifying with other members that is critical to 12-step recovery (Chi, Kaskutas, Sterling, Campbell, & Weisner, 2009; Kelly, Brown, Abrantes, Kahler, & Myers, 2008). Researchers have called for life stage and

context-sensitive strategies that can significantly impact youths' recovery rates and help them establish healthy lifestyles (Spear & Skala, 1995; SAMHSA, 2009). A social environment supportive of recovery that fosters social connectedness is essential to youths sustaining a drug free lifestyle. Central to the youth-specific context are school and peers: staying in school, functioning effectively at school, engaging in non drug-related leisure activities, establishing friendships with non drug-using peers including peers in recovery, and having effective coping strategies to deal with exposure to peers' substance use are therefore recommended elements of an effective continuum of care for youths (Spear & Skala, 1995). Currently, in spite of high SUD rates and of the high prevalence of relapse triggers in youths' social context, we lack a comprehensive continuum of care system for youths (Spear & Skala, 1995; SAMHSA Office of Communications, 2009).

Though experts have long noted the lack of campus-based services for recovering students and called for research on this population (Dickard et al., 2011; Doyle, 1999), few have heeded the call (Bell et al., 2009; Botzet, Winters, & Fahnhorst, 2007; Cleveland, Harris, Baker, Herbert, & Dean, 2007). Recovering SUD students are a “hidden group” to both researchers and college personnel (Woodford, 2001). Universities' efforts to address substance use understandably focus on prevention, screening and treatment (Cimini et al., 2009; DeJong, Larimer, & Wood, 2009; Nelson, Toomey, Lenk, Erickson, & Winters, 2010; Saltz, Welker, Paschall, Feeney, & Fabiano, 2009; Winters et al., 2011). The US Department of Education recently noted that “while academic institutions have been at the forefront of preventing substance use, the education system`s role as part of the recovery and relapse prevention support system is still emerging” (Dickard et al., 2011, p. 10). Campus-based relapse prevention resources are typically scant, consisting of 12-step meetings and an unknown number of institutions offering “sober dorms” (Finn, 1997; Join Together News Summary, 2005; Laitman & Lederman, 2007) whose usefulness is not known. Other needed services – campus-based supportive recovery community, relapse prevention and coping skills to negotiate high risk interactions with substance using peers, skills training (e.g., time management), counseling, sober social activities, supportive staff, academic and financial support, are generally either non-existent or outsourced off campus, which is costly and interferes with classes (Dickard et al., 2011; Misch, 2009). Federal agencies have called for the expansion of community based recovery support models to extend the continuum of care, including in schools and colleges (ONDCP, 2010; U.S. Department of Education Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention, 2010). The developmental stage of SUD youths and the unique challenges of college suggest the need for appropriate infrastructure on campus to support students committed to recovery (Botzet et al., 2007; Misch, 2009). This infrastructure is the core of an innovative campus-based relapse prevention approach, the *Collegiate Recovery Program*, described in the following sections.

Collegiate Recovery Programs: An innovative campus-based recovery support model

In the mid-1980's, a handful of universities started recognizing the need to provide support to college students in recovery from drug and alcohol use disorders as part of their broader effort to address substance use on college campus. These campus-based Collegiate Recovery Programs (CRPs) generally offered drug/alcohol-free housing, onsite recovery support meetings (e.g., Alcoholics and Narcotics Anonymous) and counseling provided by a small core staff (Botzet et al., 2007; Cleveland et al., 2010; Harris et al., 2008; Laitman & Lederman, 2007;Smock, Baker, Harris, & D'sauza, 2011; U.S. Department of Education Higher Education Center for Alcohol and Other Drug Abuse and Violence Prevention, 2010; White, 2001; White & Finch, 2006). CRPs' goal is to allow recovering students to extend

their participation in a continuing care program without having to postpone or surrender achieving their educational goals. Thus CRPs strive to create a campus-based “recovery friendly”' space and supportive social community to enhance educational opportunities while supporting continued students' recovery and emotional growth (Harris et al., 2008; White, 2001). As described in a handful of reports, these programs fit the paradigm of continuing care within a “recovery management” system that experts recommend (Godley et al., 2002). The model is also consistent with calls for appropriate campus-based infrastructure to support recovering students (Misch, 2009), with recent shifts in drug policy (ONDCP, 2010), and with the US Department of Education's goal of ensuring a continuum of care from high school to college to post-graduation (Dickard et al., 2011).

Through the 1990s, CRPs remained small programs, attracting little attention from educators, researchers or federal agencies. About a decade ago, as substance use among youths and in particular, on college campuses, became increasingly recognized as a major public health concern by academic institutions and federal agencies, colleges and universities became interested in the CRP model. At about the same time, as SUDs were being conceptualized as chronic conditions for many (McLellan et al., 2000), the need for a continuum of care was increasingly noted (McKay, 2001) and SAMHSA began promoting a recovery-oriented, “chronic care” approach to SUD services (Clark, 2008). In 2005, SAMHSA and the US Department of Education provided funding to Texas Tech University (TTU), one of the pioneer institutions with a CRP since 1986 (formerly lead by the second author), to provide technical assistance to universities interested in starting CRPs (Harris, Baker, & Thompson, 2005). In 2011, the Office of National Drug Control Policy (ONDCP) included its goal of building on that federal investment “to develop and disseminate information on a model collegiate recovery community curriculum” in partnership with the US Department of Education in the President's Drug Strategy (ONDCP,, 2011, p. 40). These factors combined have fueled a rapid growth in CRPs from four programs in 2000 to 33 in 19 states today, serving an estimated 600 students currently (Table 1). Thus the number of CRPs has grown by more than eight-fold in the past decade. Moreover, many CRPs report that the annual number of student applicants exceeds capacity, further *testifying to the need for such programs.* (e.g., Texas Tech, serving 65 students per semester, receives in excess of 25 additional qualified applicants annually who are declined because of capacity limit).

What we know about Collegiate Recovery Programs

The rapid development of CRPs, while highlighting the need for these services, is occurring without a formal model or a solid empirical basis to guide service planning since we currently lack knowledge about college students in recovery. Individual CRPs are developed independently of one another, typically at the initiative of interested faculty and/or a small group of recovering students. As a result, while sharing the goals of providing a campus-based supportive recovery community, preventing relapse and promoting academic performance, individual CRPs likely vary greatly on key dimensions that may influence student outcomes, such as structure, range and comprehensiveness of services, entry and participation requirements (Bell et al., 2009; White & Finch, 2006)

Published reports are available about the CRPs at Rutgers, New Jersey, Texas Tech, Texas, and Augsburg College, Minnesota, established independently in 1983, 1986 and 1995, respectively (Botzet et al., 2007; Harris et al., 2008; Laitman & Lederman, 2007). Common across sites are a campus based location, drug-free housing options, individual or group counseling to discuss recovery and academic issues, relapse prevention “life skills,” and sober leisure activities; peer support and 12 step tenets are typically emphasized. Each site operates with a core small professional staff (2 to 6). Significant differences are also noted among these 3 CRPs in terms of entry requirements - e.g., whether treatment history is

required, minimum duration of abstinence ranging from 3 to 12 months (though *how* abstinence is verified is not specified); participation requirements (e.g., whether residing in sober housing is required, use of signed behavioral/sobriety contract); level of supervision (e.g., whether urine samples are collected when substance use is suspected), cost to students (2 CRPs charge students, one is free) and comprehensiveness of services (e.g., weekly seminars on addiction, availability of CRP-specific peer tutoring and academic advising).

Outcome reports are scant as well and limited to historical records at TTU and Augsburg; they bear on two domains: (1) Academics: TTU CRP students' average *GPA* (3.18) is consistently higher than the overall TTU undergraduate GPA (2.93) (Harris et al., 2008); the Augsburg CRP reports only a mean GPA of 3.2 between 1997 and 2010[a]. TTU also publishes its CRP graduation rate (70%) that exceeds both TTU's 60% average[b] and the national average of 55.9% (National Center for Higher Education Management System, 2010). (2) Relapse rates: Since 2002, the TTU CRP relapse rates (defined as “any use”) per semester range from 4.4% to 8% (mean 6%) (Cleveland et al., 2007; Harris et al., 2008). Augsburg's mean relapse rate from 1997–2010 is somewhat higher (13%). These rates represent the total number of relapsed students in a given semester, divided by the number of students *served* that semester. Each relapse episode is counted (Harris et al., 2008). Unlike GPA and graduation rates that universities document in details, there is no comparable relapse rate available for recovering students not enrolled in CRPs; moreover, because CRP students average 2 years of abstinence (Cleveland et al., 2007), their outcomes cannot be compared with treatment or to aftercare evaluation outcomes since such studies typically report only past 30 or 90 day outcomes (Godley et al., 2010). As an estimate, we may compare CRP relapse rates to rates reported in a prospective study of community-based adults in abstinent recovery from drug-dependence and not enrolled in treatment (mean age: 43; N = 354) (Laudet & White, 2008). At study intake, the mean duration of abstinence was 31.6 months. At one-year follow-up, 34% of the sample had returned to drug use. Specifically, 57% of those drug abstinent under 6 months at intake, 41.5% of those drug abstinent 6 to < 18-months at intake, and 15.9% of those abstinent 18 to 36 months at intake had returned to drug use at one year follow-up. While not directly comparable, these rates suggest that reported CRP relapse outcomes are sufficiently encouraging to warrant a systematic evaluation of the approach.

What we need to know about Collegiate Recovery Programs

Numerous institutions interested in developing a CRP cite the lack of a formal model and systematic evaluation data as obstacles to gaining internal institutional support to start a CRP, even though they recognize the need. The need to systematically evaluate CRPs is also noted in a report issued by the US Department of Education in May 2011; with the goal of ensuring a continuum of care from high school to college to post-graduation. The report calls for prospective studies on substance use and academic outcomes among students in CRPs to inform the higher education system's response to college students in recovery (Dickard et al., 2011). The authors of this article recently received funding from the National Institutes of Health to conduct an exploratory study of CRPs and their students as a first step in planning a systematic, rigorous evaluation of CRPs. The study will survey all existing programs and their students nationwide. At the program level, we will document the diversity of structure, range and comprehensiveness of services of the existing CRPs, as well as entry and participation requirements. At the student level, we will collect detailed information about students' addiction history and severity, paths and strategies to initiating recovery (e.g., treatment, recovery school, wilderness program, juvenile justice), to

[a] http://www.augsburg.edu/stepup/outcomes.html
[b] http://www.irim.ttu.edu/CDS/2009CDS/CDS-B.htm

sustaining recovery until college (services utilization) and why they enrolled in a CRP. We will also examine college-specific recovery challenges and service needs, and be able to start characterizing an untapped subpopulation: SUD youths who sustain recovery, establish a drug free life, complete high school and go on to college. While this group may be the exception rather than the norm, information about their recovery paths and the resources/ strategies they used to sustain remission can be highly useful to continuing services development.

Conclusion

The need for recovery support among college students with a former SUD is gradually being recognized and addressed by an innovative campus-based model that has been rapidly embraced yet remains to be systematically documented and evaluated. A small NIH study is underway to describe both program structures and students' characteristics and needs in preparation for a much needed large scale evaluation. It is our hope that this paper will increase awareness of the recovery support needs of college students, encourage academic institutions to develop programs to meet these needs, and researchers to examine their outcomes.

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Table 1

List of Collegiate Recovery Programs

Institution Name	STATE	YEAR STARTED	Current student enrollment
Rutgers University	NJ	1983	21
Texas Tech University	TX	1986	65
Loyola	IL	1990	5
Augsburg College	MN	1995	91
University of Massachusetts	MA	2004	13
Tulsa Community College	OK	2005	30
University of Virginia, Charlottesville	VA	2006	8
Kennesaw State University	GA	2007	50
University of Texas, Austin	TX	2004	20
Georgia Southern University	GA	2008	30
The College of St. Scholastica, Duluth	MN	2008	9
James Madison University	VA	2009	5
William Patterson University	NJ	2009	16
Baylor University	TX	2010	4
Greenfield Community College	MA	2010	8
Ohio University	OH	2010	3
Southern Oregon University	OR	2010	15
University of Michigan, Ann Arbor	MI	2010	15
University of Mississippi	MS	2010	6
University of Vermont, Burlington	VT	2010	12
Vanderbilt University	TN	2010	27
University of Califiornia Riverside	CA	2011	6
St. Cloud State University	MN	2011	9
Penn State University	PA	2011	18
University of North Carolina, Charlotte	NC	2011	9
University of Southern Mississippi	MS	2011	19
Wayne State University	MI	2012	6
Auburn University	AL	2012	10
Midland College	TX	2012	20
University of Alabama	AL	2012	20
University of California, Santa Barbara	CA	2012	5
University of Nevada, Reno	NV	2012	15
University of Oklahoma	OK	2012	10
TOTAL STUDENTS			**600**