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Collegiate Recovery Programs: The Integrated Behavioral Health Model

Robert D. Ashford ^a, Austin M. Brown ^b, and Brenda Curtis ^c

^aJBS International, Inc., North Bethesda, MD, USA; ^bCenter for Young Adult Addiction and Recovery, Kennesaw State University, Philadelphia, PA, USA; ^cCenter on the Continuum of Care in the Addictions, University of Pennsylvania, Kennesaw, GA, USA

ABSTRACT

Campus-based recovery programs have been shown to support students in recovery from substance use disorders, as well as mental health disorders. However, this support has been historically delivered in isolation. This study highlights preliminary outcomes from a novel collegiate recovery program, one that uses a model of recovery with integrated support services for students in recovery from substance use or mental health disorders, or co-occurring behavioral health disorders. Similar to traditional collegiate recovery programs, beneficial services of the integrated program were most often related to peer-based services. Outcomes were also similar, with students in recovery having higher than average Grade Point Average ($M = 3.68$, $SD = .34$) and lengths of recovery time ($M = 3.69$, $SD = 2.87$ [years]).

KEYWORDS

Addiction; mental health; behavioral health; collegiate recovery; higher education

Introduction

Collegiate recovery programs and communities have grown substantially since 1977, when the first formal campus recovery program was started at Brown University (White & Finch, 2006). Currently, more than 60 formal collegiate recovery programs (CRPs) exist that utilize campus based-recovery and peer support services (Association of Recovery in Higher Education [ARHE], 2016; Laudet, Harris, Winters, Moberg, & Kimball, 2013). Additionally, more than 100 universities now have start-up collegiate recovery program efforts (Transforming Youth Recovery, 2016).

CRPs have been guided by a 12-Step abstinence-based framework, driven in part by the seminal knowledge in the field and the replication curriculum created and disseminated by one of the earlier programs in the country at Texas Tech University—the Center for the Study of Addiction and Recovery (CSAR) (Harris, Baker, & Thompson, 2005; Harris, Kimball, Casiraghi, & Maison, 2014). Much of the orthodoxy of this specific collegiate recovery conceptualization was based in ecological modeling (Bronfenbrenner, 1979), Eriksonian developmental psychology (Cleveland, Harris, & Wiebe, 2010),

and the “recovery paradigm” (Best & Lubman, 2012); the latter of which marked a significant shift toward behavioral health (e.g., substance use and mental health disorders) rehabilitation ideology that is operating from a set of beliefs focused on treating the substance misuse and mental health of individuals in an effort to rehabilitate them to higher life functioning. Conceptually, CRPs include several structural similarities adapted from modern evolutions in behavioral health, particularly community and peer-based support services. However, though CRPs have been rooted in behavioral health practices, the primary focus has typically been substance use given the influence of the 12-Step abstinence-based framework early models were built upon.

CRPs most often employ the following practices and services, which serve to accomplish the enmeshment of the recovery lifestyle and academic endeavors thereby supporting students in their active recovery: campus-based supportive recovery community (peer based), relapse prevention (recovery protection) and positive coping skills, skills training (life and social), case management, counseling, substance free prosocial activities, supportive staff (professional and student staff), academic and financial support, and recovery-focused living environments on campus (Harris et al., 2014; Laudet, Harris, Kimball, Winters, & Moberg, 2014; Smock, Baker, Harris, D’Sauza, 2011).

The ARHE has also provided guidelines beyond the Texas Tech program model. The guidelines, formulated in 2015, including a primary focus on substance use abstinence-based recovery, available clinical programming, and other service efforts such as housing. The guidelines were formulated to protect the organization’s core mission of supporting students recovering from abstinence-based substance use disorder in a perceived “abstinence-hostile” (Cleveland, Harris, Baker, Herbert, & Dean, 2007) environment of the college campus. According to the ARHE guidelines, “CRPs embrace abstinence-based recovery as the standard of our field,” in lieu of a specific 12-Step modality focus and that “CRPs have within them a collegiate recovery community with students in recovery from their alcoholism and/or drug addiction as the primary focus” (ARHE, 2015).

Upon review of a nationally representative data set (2002–2003 National Epidemiological Survey of Alcohol and Related Conditions [NESARC]), Blanco et al. (2008) found that almost one half of all college students met the Diagnostic and statistical manual of mental disorders 4th edition (DSM-IV) (American Psychiatric Association, 2000) criteria for at least one mental disorder in the previous year, including 18% for a personality disorder, 12% for an anxiety disorder, and 11% for a mood disorder. Additionally, the National Alliance of Mental Illness (NAMI; 2012) found that among college students who had experienced mental health challenges, 64% had withdrawn or dropped out of school because of these challenges. Yet, despite the advancements and growth in the field of collegiate recovery, the lack of

intentional supportive services for college students in recovery from either mental health disorders as a primary diagnosis, or co-occurring substance use and mental health disorders, has presented a significant gap in recovery support services on college campuses. However, the community-based nature and peer-focused supports that represent the core services of CRPs are similar to those services identified as beneficial to mental health recovery (Chinman et al., 2014). Thus, a natural overlap likely exists between supporting students in recovery from substance use and mental health disorders, or co-occurring disorders. However, this overlap has yet to be defined and studied extensively within the collegiate recovery field.

Mental health recovery programs on college campuses exist through supportive educational programs and should be noted within the framework of discussing collegiate recovery for the full range of behavioral health disorders. Supported education programs (SEP) were created to support students in recovery from psychiatric and mental health disorders (Beardsley, Kessler, & Levin, 1984; Unger, 1998). SEPs emerged on a similar timeline to CRPs, having been created in the mid-1980s. Based in large part on supported employment programs, SEPs focus on providing accommodations to promote success among students with mental health disorders wishing to return to school; this is primarily done through “accommodations, follow-along support, and enrollment assistance” (SAMHSA, 2011).

In 2013, the University of North Texas (UNT) created a model of CRP that intentionally combined elements of traditional CRPs and SEPs, with the goal of supporting students that were in or seeking recovery across the behavioral health disorder continuum (e.g., substance use disorders, mental health illness, and other quality-of-life concerns) (Holtz, Ashford, Kaigi, & Callaghan, 2015). This model, labeled the Integrated Behavioral Health Collegiate Recovery Program (IBHCRP), does not have a locus on 12-Step modality but rather focuses on more holistically supporting students through comparable services to traditional CRPs and SEPs (e.g., peer support services, academic advising, supportive housing, enrollment assistance, and drop-in center availability).

Previous research has shown that students engaged in CRPs are likely to have higher Grade Point Averages (GPAs; i.e., a scaled system used frequently in the United States to relate academic achievement in classes, most often on the 4.0 scale), retention rates, and graduation rates, as compared to the national college student mean. Additionally, as a hallmark of substance use disorder recovery success, CRPs have historically had a recurrence of use (i.e., relapse) rate as low as 8% (Laudet, Harris, Kimball, et al., 2014; Laudet, Harris, Winters, et al., 2013).

The current study seeks to provide an exploratory overview of the integrated behavioral health collegiate recovery program and IBHCRP model at UNT. In doing so, we hope to provide evidence of similar positive outcomes

(e.g., GPAs, recurrence of use rates, etc.) and identified beneficial services to students in recovery, as compared to the traditional CRP model and programs. Primary hypotheses for the study were defined a priori that the IBHCRP model would provide for similar outcomes as other CRP models, and that student-identified beneficial services would focus on peer-based services. Correlation analyses were also conducted as an exploratory process into identifying additional primary and secondary hypotheses in follow-up studies.

Method

Survey design

We conducted an anonymous Internet survey of graduate and graduate students at the UNT participating in the Psychology Department's Sona System, using a mixed-methods descriptive design (Creswell & Clark, 2011). The survey consisted of a demographics battery, an assessment of recovery capital (ARC) (Groshkova, Best, & White, 2013), a survey of quality of life (WHO-QOL BREF) (World Health Organization, 1998), and study-specific questions related to recovery status and CRP involvement. The survey took 15 to 20 minutes to complete.

Participants were excluded from the current analysis if they did not complete the survey, or if they indicated that they were not in recovery. Students that did not indicate they were in recovery were then given an electronic administration of the Substance Abuse Subtle Screening Inventory (SASSI-3) (Lazowski & Miller, 1997), Life Events Checklist (LEC-5) (Gray, Litz, Hsu, & Lombardo, 2004), and PTSD Civilian Checklist (PCL-C) (Ruggiero, Del Ben, Scotti, & Rabelais, 2003); the data collected from these administrations was utilized in another study and not included here.

The survey did not use cookies nor did it collect IP addresses or other location information. The survey and the corresponding study were approved by the Institutional Review Board (IRB) at UNT under expedited review for human subjects research.

Survey distribution and data collection

The survey had the potential to reach any undergraduate and graduate student participating in the UNT Psychology Sona System ($N = 2,100$). 19% of potential respondents initiated the survey ($n = 399$), and 80% of the initiated surveys were completed ($n = 321$). Of the 321 completed surveys, 54 (16.8%) respondents indicated they were in recovery and were included in final analysis. In the first portion of the survey, respondents provided demographic information (e.g., age, gender, sexual orientation, academic classification, and current

GPA) as well as general information specific to their recovery status and involvement with the collegiate recovery program (e.g., do you or have you ever had a substance use disorder, mental health illness, or other quality-of-life concern; do you consider yourself in long-term recovery from one of these concerns?; how long have you been in recovery?; do you actively participate in the UNT Collegiate Recovery Program?; what services do you believe are most beneficial to your recovery in the CRP?). The second portion asked respondents to complete ARC and the World Health Organization Quality of Life Brief Questionnaire (WHOQOL-BREF).

Data analysis

We carried out all study analysis via SPSS (V22.0). SPSS was used to compute summary statistics as well as to calculate Spearman's rho correlations between total measurement scores of the ARC and WHOQOL-BREF, and nonlinear independent variables. We defined statistical significance a priori using an alpha of 0.05.

Participants

The final sample consisted of 54 students at UNT that identified as in recovery. Table 1 contains summary statistics for age, gender, sexual orientation, GPA, academic classification, behavioral health disorder type, and recovery length of participants.

Results

Recovering students

54 students (16.8%) identified that there were in recovery from a behavioral health disorder, inclusive of substance use and mental health disorders, as well as co-occurring disorders. Those in recovery from mental health disorders reported depressive and anxiety-related disorders most often, followed by disordered eating and bipolar disorder. Of the students that identified as in recovery, 25.9% ($n = 14$) also identified that they actively participate in the UNT Collegiate Recovery Program. Table 1 contains summary statistics of the participants in the CRP including age, gender, sexual orientation, GPA, academic classification, behavioral health disorder type, and recovery length.

Beneficial services offered by the collegiate recovery program

Those students participating in the CRP ($n = 14$) most often reported that the most beneficial services offered by the program were peer-related services or

Table 1. Demographic characteristics^a.

	In recovery – All		In recovery – CRP participant	
	(N = 54)		(N = 14)	
	<i>n</i>	(%)	<i>n</i>	(%)
Gender				
Male	8	(14.8)	4	(28.6)
Female	45	(83.3)	9	(64.3)
Trans	1	(1.9)	1	(7.1)
Sexual orientation				
Heterosexual	42	(77.8)	9	(64.3)
Homosexual	2	(3.7)	0	(0.0)
Bisexual	8	(14.8)	4	(28.6)
Other	2	(3.7)	1	(7.1)
Academic classification				
Freshman	8	(14.8)	1	(7.1)
Sophomore	7	(13.0)	0	(0.0)
Junior	13	(24.1)	1	(7.1)
Senior	18	(33.3)	7	(50.0)
Graduate student	8	(14.8)	5	(35.7)
Disorder type				
Substance use	25	(46.3)	10	(71.4)
Mental health	45	(83.3)	11	(78.6)
Other	15	(27.8)	4	(28.6)
Co-Occurring	25	(46.3)	12	(85.7)
	M	(SD)	M	(SD)
Age	24	(6.130)	27	(5.172)
Grade Point Average	3.482	(.446)	3.686	(.338)
Recovery length (years)	3.93	(2.604)	3.69	(2.869)
Primary program of recovery				
12-Step	12	(22.2)	7	(50.0)
Non-12-Step abstinence	5	(9.3)	2	(14.2)
Harm reduction	1	(1.9)	1	(7.1)
MAT	1	(1.9)	0	(0.0)
Therapy	25	(46.3)	3	(21.4)
Peer support nonabstinent	4	(7.4)	0	(0.0)
Other	6	(11.1)	1	(7.1)

Note. CRP = Collegiate Recovery Program; MAT = Medication-Assisted Treatment.

^a In recovery-all grouping contains students that participate in the CRP as well as students that do not.

resources, including recovery meetings. Additionally, responses for students in recovery from substance use and mental health disorders were near equivalent as it related to beneficial services offered by the program. [Figure 1](#) provides a summary of the most beneficial services for students as a whole and then is further separated by type of recovery.

Recovery Pathways

Overall, students in recovery that did not participate in the CRP, utilize professional therapy most often as their primary program of recovery (46.3%). 12-Step programs and non-12-Step abstinence-based programs were the next most common primary programs of recovery (22.2%, 9.3%, respectively).

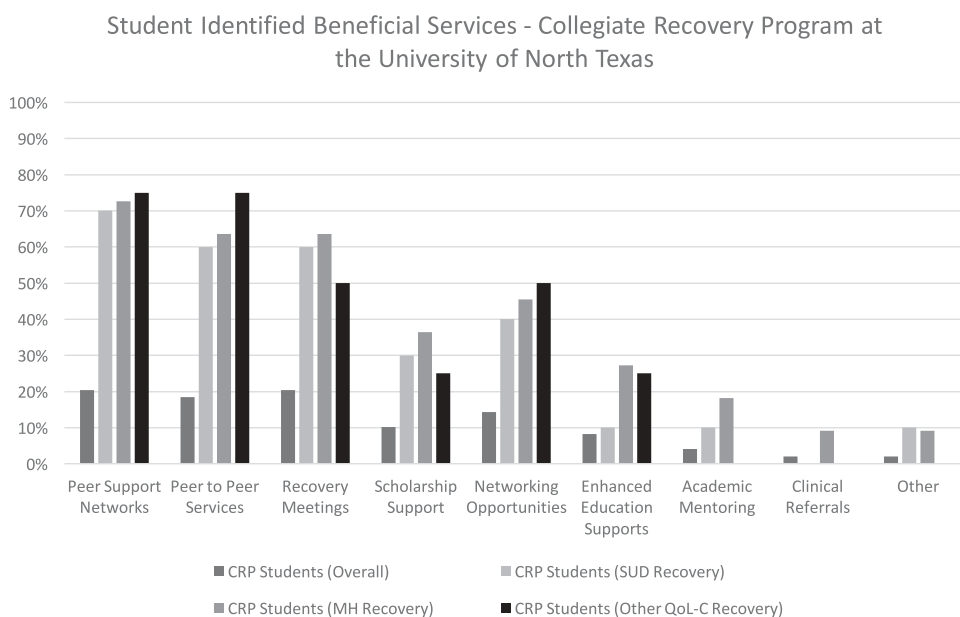


Figure 1. Percentage of students responding to most beneficial services to personal recovery offered by the collegiate recovery program.

Note. CRP = Collegiate Recovery Program; MH = Mental Health; SUD = Substance Use Disorder; QoL-C = Quality of Life Concern.

Students in recovery that participate in the CRP most often use 12-Step programs as their primary program of recovery (50%), followed by professional therapy (21.4%) and non-12-Step abstinence-based programs (14.2%). [Table 1](#) provides summary statistics of all primary programs of recovery for students.

Correlations

Bivariate correlation analysis using the Spearman's rho correlation found no significant correlations between any demographic variable and recovery length, total ARC scores, or the total scores from any of the WHOQOL-BREF domains. However, significant positive correlations were found to exist between total ARC scores and CRP scholarship assistance services ($r_s = .557$, $p = .039$), and the WHOQOL-BREF psychological domain and CRP scholarship assistance services ($r_s = .612$, $p = .020$).

Discussion

Students that participate in the integrated behavioral health collegiate recovery program at UNT identified that peer-related services are among the most

beneficial to their personal recovery. This finding is consistent with previously conducted research (Botzet, Winters, & Fahnhorst, 2008; Cimini et al., 2009; Cleveland et al., 2007; Laudet, Harris, Kimball, et al., 2014) that shows peer-related services are among the most beneficial services at traditional programs. Additionally, we found that students in substance use and mental health disorder recovery identified that peer-related services were most beneficial, supporting the notion that integrated CRPs, and the students they serve, are also likely to view peer-based services as the most useful in providing support for personal recovery, irrespective of the type of disorder they are recovering from.

Students were on average older than the traditional college student (Snyder, de Brey, & Dillow, 2016), but students participating in the collegiate recovery program were slightly older than students in recovery not participating in the program. Overall, students that identified as being in recovery but not participating in the CRP skewed toward a self-identified female gender, though students participating in the CRP did trend toward a more even gender distribution. Consistent with previous research (Harris, Baker, Kimball, & Shumway, 2008; Laudet, Harris, Kimball, et al., 2014), students engaged in the CRP had higher than average GPAs than recovery students who did not participate in the program and the average of all University students.

Students in recovery reported a variety of programs as their primary program of personal recovery—including professional therapy, 12-Step programs, and non-12-Step abstinence-based programs. Although roughly one half of the students engaged in the CRP did identify 12-Step programs as their primary program of recovery, professional therapy and non-12-Step abstinence-based programs were notably high as compared to more traditional CRPs in the country (Laudet, Harris, Kimball, et al., 2014).

Among the notable findings are the statistically significant positive correlations between ARC scores and WHOQOL-BREF psychological domain scores with students who identified scholarship support services as beneficial. These positive correlations suggest that scholarship assistance may positively increase the psychological quality of life and recovery capital of students, leading to more positive outcomes while enrolled in the program.

The amount of students (16.8%) identifying as in recovery from behavioral health disorders suggests that the number of students in recovery on college campuses may be higher than the previously suggested 4% (Harris et al., 2005). Similarly, the number of students choosing to participate in a CRP (25.9%) suggests that the need for CRPs may be higher than previously thought (Clements, 1999). This increase is likely linked to using behavioral health disorder recovery, rather than substance use disorder recovery singularly, as well as the increase in young adults initiating the recovery process in the United States over the last decade (Center for Behavioral Health Statistics and Quality,

2015). However, these increases provide an indication of an enhanced need for integrated recovery support services on college campuses, with a focus on those services that are beneficial to the full continuum of behavioral health recovery.

Colleges and universities likely make the decision to institutionally support, or not to support, student service programs, such as CRPs, based in part on the number of students they are likely to serve over a given time period. The prevalence of students in behavioral health recovery, as opposed to substance use or mental health recovery alone, provides an opportunity for programs to increase the potential scope and impact of their programs, likely resulting in an increase in potential institutional support (e.g., funding and space).

Study limitations

This study is the first focused on the IBHCRP model and provides an important basis for further study. Similar to traditional CRPs, the results suggest that integrated behavioral health programs have the potential to provide beneficial services to students in recovery, however it is a one-site study and nonlongitudinal. It is also important to note that UNT is a national leader in behavioral health sciences, counseling psychology, as well as disability and rehabilitation counseling; as such, the overall institutional pedagogy was primed for supporting behavioral health integration at the programmatic level—a condition that may not be easily replicated elsewhere. However, the study results show strong similarity between previous multisite cross-sectional studies that have been completed. These results provide strong confidence that the IBHCRP may be as impactful as traditional CRPs. The response rate of those eligible to participate (19%) should also be seen as a potential limitation. However, this response rate is typical of other responses in studies advertised in the UNT Sona system, as incentives are limited to extra credit in coursework. Future studies should increase the modes of recruitment as well as adding financial incentive possibilities. Additionally, the sample size, though a sizeable portion of the overall recruited participants, is not large enough to provide results that are generalizable to all college students and college campuses.

Implications for further services and research

These findings support the further study of the IBHCRP model at institutions of higher education. Although fully integrated models on par with the UNT are not widespread, a significant number of programs provide some level of integrated behavioral health services that may be studied to provide further evidence of mutually beneficial relationships of integrated and intersectional recovery support services. Additionally, CRPs of any framework and design should strive to increase the amount of peer-related support services offered

to their students to meet various self-identified needs. Given that communities of support are the operative centerpiece of collegiate recovery efforts, program administrators should remain sensitive to the needs of students in co-occurring or mental health recovery, even if not operating within the full context of the IBHCRP model.

Future research should be informed by the current study, including the longitudinal study of traditional and IBHCRPs. Replication of the current study should also be a priority to verify the current findings supporting an increase of the number of students in recovery on a college campus, as well as the increase in the number of students seeking help from a disorder. Studies should also attempt to further compare outcomes of traditional programs to integrated programs, seeking to find any significant differences in outcomes and efficacy. Areas of overlap between existing mental health support structures mandated by university systems and CRPs should also be examined to identify areas that may lack peer-driven supports and educational supports. Comparative research should be aimed developing controlled comparisons within the larger traditional student body, as well as across minority groupings (e.g., LGBTQ+, veterans, disability services, etc.), to delineate what areas of peer support are most helpful to recovering students in particular and how those needs may differ from other populations. Feasibility and sustainability studies should also incorporate need-specific viability of integrated behavioral health models, student organizations, and their ensuing outcomes.

ORCID

Robert D. Ashford  <http://orcid.org/0000-0003-3979-1754>

Austin M. Brown  <http://orcid.org/0000-0001-9958-3696>

Brenda Curtis  <http://orcid.org/0000-0002-2511-3322>

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