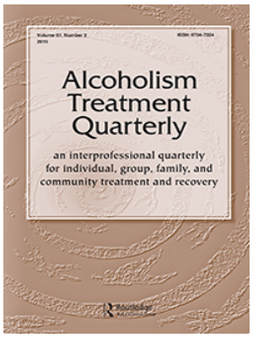

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Alumni Characteristics of Collegiate Recovery Programs: A National Survey

Austin M. Brown [a], Robert D. Ashford [b], Naomi Figley[a], Kayce Courson[a], Brenda Curtis [b], and Thomas Kimball[c]

[a]Kennesaw State University, Center for Young Adult Addiction and Recovery, Kennesaw, Georgia, USA; [b]Department of Psychiatry, Addictions, University of Pennsylvania, Philadelphia, Pennsylvania, USA; [c]Texas Tech University, Lubbock, Texas, USA

ABSTRACT

Collegiate recovery programs (CRPs) support students in or seeking recovery from substance use disorders or mental health disorders while enrolled in college. Collegiate recovery has been established as a field of study since the 1970s. To date, a number of qualitative studies have been completed on the programs and students served, along with a single national descriptive survey. This pilot study is the first undertaken exploring the status (recovery, professional, and quality of life) of student alumni that engaged in undergraduate collegiate recovery programs (CRP). Results contain alumni recovery status, primary recovery supports utilized, relapse rates since graduation, and recovery capital/quality of life scores. Similar to previously published works, CRP alumni remain actively in recovery, with relapse rates only slightly higher than the national average of students currently engaged in CRPs (10.2% vs. 6.8%). Findings are preliminary evidence that collegiate recovery programs adequately prepare engaged students for future recovery and professional life.

KEYWORDS

Collegiate recovery; addiction; higher education; recovery; substance use disorder; behavioral health

Introduction

Collegiate recovery programs (CRPs) began in the late 1970s at Brown University (White & Finch, 2006) and have since grown considerably. Currently there are more than 160 programs in the United States (Association of Recovery in Higher Education, 2016; Transforming Youth Recovery, 2016). Although there is no specific definition of a CRP, the Association of Recovery in Higher Education (ARHE; 2016) state that CRPs are nonprofit entities that exist within the larger ecology of college campuses with dedicated staff and space, a community of students engaged in a recovery lifestyle that staff support through a variety of ongoing, peer-based efforts.

CRPs strive to create a campus-based "recovery-friendly" space and supportive social community to enhance educational opportunities while supporting

CONTACT Robert D. Ashford roberdav@upenn.edu Department of Psychiatry, Addictions, University of Pennsylvania, 2111 Melvin St., Philadelphia PA

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students' continued recovery and emotional growth (Bugbee, Caldeira, Soong, Vincent, & Aria, 2016). CRPs typically support students in two main ways: (1) academic support (scholarships, recovery-cognizant academic advising/study spaces) and (2) recovery support (on-campus recovery meetings, peer-based social support, counselling) (Laudet & Humphreys, 2013).

Previous examinations of CRPs have often either been descriptive of the students who use CRPs services or focused on student experiences while participating in a CRP (Kimball, Shumway, Harris, & Austin-Robillard, 2016; Laudet, Harris, Kimball, Winters, & Moberg, 2016). Laudet, Harris, Kimball, Winters, and Moberg (2015) were the first to capture nationwide data on 486 CRP students who were enrolled in 29 CRPs across the country. This data included recovery group affiliations, treatment, and mental health histories, as well as relapse, criminal justice histories, physical and emotional health, and grade point averages among other self-reported items.

However there have been no published studies examining CRP students' postgraduation and longitudinal outcomes. The present pilot study provides the first examination of postgraduate collegiate recovery students (i.e., CRP alumni). The goal of this preliminary pilot study is to examine CRP alumni relapse rates, quality of life, recovery progress, and well-being. This is linked to the overarching theoretical orientation of previous collegiate recovery research that involves (1) social capital, defined as bidirectional social integration (Granfield & Cloud, 1999) and (2) recovery capital, which consists of social capital, physical capital, human capital, and cultural capital (Harris, Baker, & Cleveland, 2010; Laudet & White, 2008), all of which have been linked to better outcomes for those in substance use disorder (SUD) recovery (Granfield & Cloud, 2001; Laudet, 2008, 2011).

Method

Participants

Participants (N = 88) were self-reported alumni of CRPs at institutions of higher education in the United States. Demographics of the respondents yielded a mean age of 30.13 years (SD = 6.89), 54.5% of participants were male, and 96.6% were White. More than 50% reported being single/never married, and 79.5% of participants were employed either full- or part-time. Of the participants, 47.7% had an annual total family income over $50,000. Most participants, 96.6%, reported being in recovery at the time of the survey, with 83.5% of those stating that mutual aid (12-Step) was the primary program of recovery used. See Table 1 for full demographic characteristics for participants.

Table 1. Collegiate Recovery Program alumni – demographic characteristics.

	(*N* = 88)	
	n (*M*)	(%) (*SD*)
Age (years)	30.13	(6.89)
Recovery length (months)	89.98	(43.07)
Gender		
Male	48	(54.5%)
Female	39	(44.3%)
Trans	1	(1.1%)
Race/ethnicity		
White	85	(96.6%)
Black/African American	1	(1.1%)
American Indian/Native American	1	(1.1%)
Asian/Pacific Islander	1	(1.1%)
Latino Origin or Descent	3	(3.4%)
Marital status		
Single, never married	48	(54.5%)
Married/domestic partnership	37	(42.0%)
Widowed/divorced	3	(3.4%)
Education level		
4-year degree	65	(73.9%)
Postgraduate degree	23	(26.1%)
Employment status		
Employed	70	(79.5%)
Out of work and looking	1	(1.1%)
Unable to work	1	(1.1%)
Homemaker	1	(1.1%)
Current student	15	(17.0%)
Household income		
Less than $10,000	3	(3.4%)
$10–29,999	19	(21.6%)
$30–49,999	24	(27.3%)
Over $50,000	42	(47.7%)
Recovery status		
Currently in recovery	85	(96.6%)
Reoccurrence of use (Relapse)		
No use since graduation	77	(87.5%)
Use since graduation	9	(10.2%)
Not applicable	2	(2.3%)
Preferred substance of use		
Alcohol	19	(21.6%)
Opiates	21	(23.9%)
Cocaine	4	(4.5%)
Amphetamines	2	(2.3%)
Marijuana	5	(5.7%)
Multiple substances	29	(33.0%)
Other	8	(9.1%)
Mental health diagnosis (lifetime)		
Depressive disorder	16	(18.2%)
Anxiety disorder	3	(3.4%)
Bi-polar disorder	6	(6.8%)
ADHD	10	(11.4%)
Multiple diagnosis	34	(38.6%)
Primary recovery pathway (Current)		
Mutual aid (12-Step)	71	(83.5%)
Mutual AID (non-12-Step)	1	(1.2%)
Mutual AID (spiritually affiliated)	1	(1.2%)

(*Continued*)

Table 1. (Continued).

	(*N* = 88)	
	n (*M*)	(%) (*SD*)
Moderation/harm reduction	1	(1.2%)
Medication-assisted	0	(0.0%)
Professional therapy	8	(9.4%)
Other	3	(3.5%)
Primary recovery pathway (CRP)		
Mutual aid (12-Step)	76	(86.4%)
Mutual aid (non-12-Step)	2	(2.3%)
Medication-assisted	1	(1.1%)
Professional therapy	7	(8.0%)
Other	2	(2.3%)
Academic disruption due to BH		
Yes	72	(81.8%)
Completed SUD treatment		
Yes	67	(76.1%)
Completed MH treatment		
Yes	36	(40.9%)
Stayed in recovery residence		
Yes	48	(54.5%)
Criminal justice (prev. 12 months)		
No involvement	82	(93.2%)
Medical complications		
Related to BH disorder	11	(12.5%)
Not related to BH disorder	18	(20.5%)

Note: ADHD: Attention Deficit and Hyperactivity Disorder; CRP: Collegiate Recovery Program; BH: Behavioral health; SUD: Substance Use Disorder; MH: Mental Health; Prev.: Previous.

Survey distribution

After obtaining Institutional Review Board approval from Kennesaw State University, a survey link along with a digital recruitment flyer calling for collegiate recovery alumni participation was distributed through electronic mail to the Association of Recovery in Higher Education listserv member schools, as well as on private social media groups specifically for CRP professionals. Digital snowball sampling was chosen for this study (i.e., the recruitment material could be forwarded freely) as no formal centralized database exists for alumni of CRP programs. Program professionals were asked to provide the study information to alumni of the respective CRPs and furnish alumni with the recruitment flyer and survey link. Total potential sample size is unknown due to a lack of historical records of CRPs and those students served since the field's inception in the 1970s. Participants who responded to the study were given the option to fill out a separate contact form, not traceable to their survey response, to be entered into a random drawing for a $50 gift card for their time.

Measures

This study deployed a battery of measures in a single online Qualtrics survey. Basic demographic data was captured including employment, education level, family income, marital status, as well as age, ethnicity, and gender identity. Several validated measures were incorporated examining quality of life, recovery capital, and human flourishing. An additional quality of life self-report five-item survey was added and deployed alongside the World Health Organization Quality of Life Brief Survey and the Assessment of Recovery Capital in hopes of capturing CRP-specific quality of life domains and was developed from qualitative information derived from previous collegiate recovery research. Additionally, self-report questions were included in the survey related to stigma, professional and personal benefits of CRP participation, personal recovery pathways, and substances used. (A copy of this survey is available in the supplemental materials).

World Health Organization Quality of Life Brief

The 26-item World Health Organization Quality of Life Brief Questionnaire (WHO-QOL BREF) is a widely used and well-validated measure of overall quality of life in a four-factor model: physical health, psychological health, social relationships, and environment (Skevington, Lotfy, & O'Connell, 2004; World Health Organization, 1998). The metric incorporates a 5-item Likert-type scale ranging from 1 (*least*) to 5 (*most*), with a midrange option (*both* or *neither*) and three reverse-scoring items. Higher scores within the questionnaire is associated with higher quality of life in the respective domain. The WHO-QOL BREF has been deployed and validated in a variety of settings, translated into more than 40 languages, and deployed across diverse disease groups. Test–retest reliability at 2 weeks yielded intraclass correlations (ICCs) of 0.75 to –0.84 (Koohi, Nedjat, Yaseri, & Cheraghi, 2017). Skevington et al. (2004), demonstrated the WHO-QOL BREF contains high-quality psychometric properties and good validity through confirmatory factor analysis, (.87 physical, .95 psychological, .83 social relationships, .84 environment) across a large sample (N = 11,830), in 23 countries, in sick and well groups, across multiple settings, and across mental health and medical groups. Additionally, some research has been done specific to the correlates of quality of life and SUD recovery (Kirouac, Stein, Pearson, & Witkiewitz, 2017; Laudet, 2011).

Assessment of Recovery Capital

The Assessment of Recovery Capital (ARC; Groshkova, Best, & White, 2012) measures key areas associated with recovery progress, especially in postacute populations. The ARC consists of 50 questions that comprise 10 subdomains: (1) substance use and sobriety, (2) global psychological health, (3) global physical health, (4) citizenship and community involvement, (5) social

support, (6) meaningful activities, (7) housing and safety, (8) risk taking, (9 coping and life functioning, and (10) recovery experience. Each item asks the respondent to indicate whether they *agree* (1) or *disagree* (2) with the statement. Each *agree* response is assigned a score of 1, whereas each *disagree* is assigned a score of 0. Higher scores are associated with higher levels of recovery capital. Validation of the measure demonstrated a correlation at or above (.80) with all WHO-QOL BREF subscales across treatment and recovery subsamples. Reliability was established through test–retest at 1 week utilizing ICC coefficients revealing a moderate or substantial reliability for each subdomain, and an overall substantial reliability (ICC = .61–0.80) of .61 (Groshkova, Best, & White, 2012).

Human Flourishing Scale

The 8-item Flourishing Scale (FS-8; Diener et al., 2010) measures perceived sense of success in participants' relationships, self-esteem, purpose, and optimism yielding a single score for well-being. The scale consists of a 1 to 7 Likert-type scale ranging from *strongly disagree* to *strongly agree*, with a midrange option of *neither agree or disagree*. Scores can range from 8 to 56, with higher scores associated with greater perceived sense of success. Validation of the metric revealed an eigenvalue of (4.24), with a single axis accounting for (53%) of variance, with factor loading of .61 to .77 (Diener et al., 2010). Test-–retest were completed at 1 month and reveal moderately high stability (Diener et al., 2010). The measure has good psychometric properties and is strongly associated with other psychological well-being scales such as the WHO-QOL BREF (Diener et al., 2010).

Additional self-report quality of life measure

In addition to the above measures, we examined participant's (1) life satisfaction in regards to eight domains (financial stability, family relations, romantic relations, friends/peer relations, professional environment, emotional stability, sense of life purpose, sense of impact on the world) with 1 (*high*) to 5 (*low*) endpoints, (2) overall physical health and wellness, and (3) overall mental health and wellness.

Data analysis

All data analysis was completed using SPSS V23. Correlation significance was defined as $p < .05$ a priori. Chi-squared tests for independence were run for the following demographic characteristics (gender, race, ethnicity, education level, and income level) to determine if any in-group differences were significant. The initial research hypothesis stipulated that stability factors for former CRP students such as employment, recovery rates, 12-Step attendance, and histories would reflect existing self-report data from previous work by Laudet et al. (2015). In addition to this, the capture of new pilot data through the use of the WHO-QOL BREF, ARC,

FS-8; Diener et al., 2010, and the self-report questionnaire on stigma and program benefits would help to shape future research and provide context for alumni characteristics.

Results

Substance use and mental health

The majority of participants (n = 88) reported presently being in recovery from a behavioral health disorder (96.6%). Of those in recovery, the current programs used to support recovery (Table 1) were most often mutual aid 12-Step (83.5%) and therapy (9.4%).

Most participants reported substance use histories involving multiple substances (33.0%), followed by opiate use only (23.9%), and alcohol use only (21.6%). A majority of participants (78.4%) had co-occurring mental health disorders, with multiple mental health diagnoses being the most prevalent (38.6%), followed by depressive disorder (18.2%).

Most participants (81.8%) had experienced past academic disruption due to behavioral health disorders and substance use. Academic disruption involves abandoning ones education dues to substance use or mental health issues and is a common feature of using careers of CRP students (Cleveland, Baker, & Dean, 2010). Additionally, many participants (76.1%) had completed SUD treatment at some point in their lives; 40.9% had completed mental health disorder treatment at some point in their lives, and 54.5% had lived in a recovery residence at some point in their lives. Of those that had lived in a recovery residence, only 11 (22.9%) stayed in a residence affiliated with the CRP.

Of those participants that reported abstinence as the primary pathway of recovery used, 87.5% (n = 86) reported no recurrences of use since graduation —representing a return to use rate of (10.2%). Of those that did return to use (n = 9), 3 participants experienced one episode, 3 participants experienced two to four episodes, and 3 participants experienced five or more episodes.

Recovery capital

Participants had mean recovery capital scores of 45.90 (SD = 4.21). Recovery capital scores were not significantly different among gender χ^2 (28) = 21.57, p = .801, race $\chi^2(42)$ = 34.91, p = .772, ethnicity χ^2 (14) = 13.83, p = .462, education level $\chi^2(14)$ = 21.33, p = .093, or income level $\chi^2(42)$ = 50.33, p = .177. Additionally, ARC scores were found to be significantly positively correlated with human flourishing scale (FS-8 scores) (r = .670, p < .001), and scores from all domains of the WHO-QOL BREF (DOM1, r = .371, p < .001; DOM2, r = .741, p < .001; DOM3, r = .606, p < .001; DOM4, r = .470, p < .001).

Table 1.2. Recovery capital, quality of life, and flourishing.

	M	(*SD*)
Recovery capital (ARC)	45.90	(4.21)
Domain - Physical (WHO-QOL)	17.29	(2.20)
Domain - Psychological (WHO-QOL)	15.58	(2.40)
Domain – Social (WHO-QOL)	15.98	(2.88)
Domain - Environment (WHO-QOL)	17.15	(1.89)
Human flourishing (FS-8)	49.69	(6.04)
Quality of life – Self-report		
Financial stability	2.25	(0.95)
Family relations	1.68	(0.70)
Romantic relations	1.89	(0.93)
Friend/peer relations	1.77	(0.89)
Professional environment	1.60	(0.65)
Emotional stability	2.03	(0.89)
Sense of life purpose	1.85	(0.93)
Sense of impact on world	1.88	(0.97)
Overall mental health/wellness	1.89	(0.84)
Overall physical health/wellness	2.24	(0.90)

Note: ARC: Assessment of Recovery Capital; WHO-QOL: World Health Organization Quality of Life; FS-8: Human Flourishing Scale.

Quality of life - self report

Participants reported the highest ratings of quality of life among the domains for professional environment (M = 1.60, SD = .65) and family relations (M = 1.68, SD = .70). Additionally, participants reported high satisfaction with overall mental and physical health/wellness, though mental wellness was rated greater (M = 1.89, SD = .84; M = 2.24, SD = .90). Full scores for the quality of life–self report measure are available in Table 1.2.

Chi-squared tests revealed self-report quality of life scores were significantly different only in two domains and by two demographic variables (income and race), by financial stability and romantic relationships. Income levels were significantly related to scores in the financial stability domain χ (9) = 31.92, p = .001, whereas those reporting an income over $50,000 annually were more likely to have higher satisfaction than those making less than $50,000 annually; income level were also significantly related to scores in the romantic relationships domain $\chi^2(12)$ = 27.69, p = .006, where those reporting an income over $50,000 annually were more likely to have higher satisfaction than those making less than $50,000 annually. Racial identification was significantly related the romantic relationships domain $\chi^2(12)$ = 27.56, p = .006, where White respondents were more likely to have higher satisfaction than non-White respondents. All chi-squared test results are available in Table 1.3.

Table 1.3. Quality of life self report results.

Self-Report QoL Domain	Variable	*df*	χ^2 Score	*p* Value
Financial stability	Gender	6	3.85	0.697
	Race	9	13.09	0.159
	Ethnicity	3	0.42	0.936
	Education level	3	6.34	0.096
	Income level	9	31.92	0.001*
Family relationships	Gender	6	3.83	0.7
	Race	9	3.4	0.946
	Ethnicity	3	4.09	0.252
	Education level	3	1.14	0.767
	Income level	9	6.18	0.722
Romantic relationships	Gender	8	5.87	0.662
	Race	12	27.56	0.006*
	Ethnicity	4	0.71	0.95
	Education Level	4	6.06	0.195
	Income level	12	27.69	0.006*
Professional environment	Gender	6	2.42	0.878
	Race	9	3.41	0.946
	Ethnicity	3	0.65	0.884
	Education level	3	1.23	0.746
	Income level	9	6.7	0.668
Peer relationships	Gender	8	2.96	0.937
	Race	12	3.73	0.988
	Ethnicity	4	1.92	0.75
	Education Level	4	5.69	0.223
	Income level	12	8.64	0.733
Emotional stablity	Gender	6	3.34	0.766
	Race	9	3.73	0.928
	Ethnicity	3	3.16	0.368
	Education level	3	5.1	0.164
	Income level	9	12.05	0.211
Sense of life satisfaction	Gender	8	2.79	0.947
	Race	12	4.81	0.964
	Ethnicity	4	0.96	0.916
	Education level	4	1.78	0.775
	Income level	12	16.39	0.174
Overall MH and wellness	Gender	6	5.75	0.451
	Race	9	4.42	0.882
	Ethnicity	3	6.23	0.101
	Education level	3	6.17	0.104
	Income level	9	6.55	0.684
Overall PH and wellness	Gender	6	5.15	0.524
	Race	9	6.82	0.656
	Ethnicity	3	7.31	0.063
	Education level	3	3.46	0.326
	Income level	9	9.39	0.402
Sense of life purpose	Gender	8	3.97	0.86
	Race	12	4.28	0.978
	Ethnicity	4	1.29	0.863
	Education level	4	1.02	0.907
	Income level	12	18.33	0.106
Sense of positive impact	Gender	8	2.2	0.974
	Race	12	4.46	0.974
	Ethnicity	4	2.71	0.608
	Education level	4	7.64	0.106
	Income level	12	8.82	0.718

Note: QoL: Quality of Life; MH: Mental Health; PH: Physical health.

Quality of life - world health organization brief

Participants were found to have higher physical and environmental domain quality of life scores (M = 17.29, SD = 2.20; M = 17.15, SD = 1.89), than psychological and social domain scores (M = 15.58, SD = 2.40; M = 15.98, SD = 2.88); Table 1.2 provides all domain scores. Quality of life domain scores were not significantly different among gender, race, ethnicity, education level, or income level. All domain scores were significantly positively correlated with ARC and FS-8 scores, however.

Flourishing

Participants had mean FS-8 of 49.69 (SD = 6.04). Human flourishing scale scores were not significantly different among gender $\chi^2(38) = 29.61$, $p = .833$, race $\chi^2(57) = 31.01$, $p = .997$, ethnicity $\chi^2(19) = 39.916$, $p = .05$), education level $\chi^2(19) = 25.08$, $p = .158$, or income level $\chi^2(57) = 63.81$, $p = .250$. FS-8 scores were significantly positively correlated with ARC scores ($r = .670$, $p < .001$) and all domain scores of the WHO-QOL BREF (DOM1, $r = .359$, $p = .001$; DOM2, $r = .800$, $p < .001$; DOM3, $r = .721$, $p < .001$; DOM4, $r = .454$, $p < .001$).

Benefits of program

The majority of respondents felt that participation in their respective CRPs helped them in several ways. A majority of participants (68.2%) felt that the CRP directly prepared them for the professional environment; whereas slightly more participants (80.7%) felt the program directly prepared them for post-graduation recovery. Additionally, most participants (89.8%) felt that program membership was helpful academically. Although not a majority, a number of participants (36.4%) also reported they would not have attended their undergraduate institution if the program had not been there. A majority of participants (81.8%) also maintained alumni contact with the undergraduate CRP.

Stigma

Some participants (37.0%) had a sense of stigmatization of their recovery status while enrolled in their CRP, and (33.0%) of participants felt a sense of stigmatization of their recovery status since graduating from college. Of these participants, 37.5% felt this stigmatization had decreased since graduating, whereas 46.6% felt that it had neither decreased nor increased.

Discussion

Although preliminary, for participants in this study it is clear that collegiate recovery is a highly positive experience preparing students in recovery for postgraduation professional and recovery success. It also is clear for most survey respondents that former affiliation with CRPs created personal recovery gains that are self-reportedly maintained after graduation and were thus stable. However, a self-selecting cohort of predominantly White respondents who affirm they are employed, earning well, entering into stable relationships, and remaining abstinent from substances is only a preliminary step into understanding the impact of CRPs long term. The ability to determine the role of the CRP in making these gains possible is promising, and the findings are supportive of previous research regarding such gains during CRP enrollment.

The strength of this particular study is that it reflects the results from previous research established on CRP students (e.g., relapse rates, employment rates, co-occurring disorder prevalence, etc.) (Laudet, Harris, Kimball, Winters, & Moberg, 2014; Laudet et al., 2015; Laudet, Harris, Winters, Kimball, & Moberg, 2014), with only slight variations. Building from previous research, there were several commonalities with the current study. For example, compared to Laudet et al. (2015), which demonstrated an 86.4% student participation rate in 12-Step programs while enrolled in CRPs, the current study shows a (83.5%) participation in 12-Step meetings in the postgraduation sample. Thus, participation in mutual aid support is nearly as high for postgraduation samples. Additional similarities include low rates of relapse of enrolled CRP students (8%) and of the postgraduation respondents (12.5%). Treatment histories, ethnic composition, and co-occurrence of mental health issues also are similar to previous studies of collegiate recovery populations.

The current study, the first to sample a cohort of CRP graduates and alumni, finds that not only are survey respondents doing relatively well in relation to employment, earnings, and recovery (e.g., abstinent alumni from the sample have experienced only a 10.2% recurrence of use, or relapse, rate), but also doing well related to life and recovery-related factors measured by the ARC, the WHO-QOL BREF, and the FS-8. Additionally, this is the first use of the FS-8 with the recovering student population, and preliminary evidence suggests a level of positive correlation between this 8-item instrument and the longer ARC (50 items) and WHO-QOL BREF (27 items). This result provides a basis for further study into the convergent validity of the FS-8 with the ARC and WHO-QOL BREF.

Although the role of the CRP in individual student success is not yet established through rigorous sampling and controls, including longitudinal and randomized control trials, two CRP cohorts (one of currently enrolled

students completed by Laudet et al., (2015) and the present study cohort of CRP alumni) have now self-reported consistent positive data across multiple measures of quality of life and human functioning (recovery capital, satisfaction, health and wellness, and flourishing). It is hoped that this initial evidence of consistency lends itself to future research interests as a pilot foray into postgraduation life of former CRP students. More rigorous sampling methods and controls can now be formulated from this design, and more causative elements of student success may be explored by CRP researchers.

The presented results should be viewed in the light of certain limitations. Although the number of CRP graduates and alumni is unknown at this time, it is unlikely that the current sample (N = 88) is representative to all CRP graduates. However, that the population size is unknown speaks to a larger issue of the lack of tracking of CRP graduates and alumni by the programs operating in the United States. These preliminary results provide support that programs should invest resources into data gathering and databases in maintaining and engaging the graduates of their programs. In fact, the CRP field general would benefit from a national database gathering an agreed-upon set of variables for current students and alumni over time. The racial disparity in the current study, though also reflected in other studies of this nature in CRPs (Laudet et al., 2015), speaks to a potentially much larger problem in the field involving a severe lack of diversity, inclusion, and opportunity for minority community students that are in recovery or seeking recovery. The lack of diversity in the CRP field is a reflection of not only the significant barriers minorities face in engaging recovery help but also within higher education. Further exploration into the racial diversity CRPs in the United States and breaking down these barriers is a critical issue, and one that should be completed as soon as possible. Any study of recovery or related phenomena that lacks significantly diverse sampling methods cannot be considered generalizable, or representative of the larger population affected by SUDs.

Conclusion

On the heels of other CRP research, this study sought to provide a preliminary glimpse into the postgraduation descriptors of former collegiate recovery students. This study sets a precedent for further study into CRP outcomes. The impact of CRPs and the growth of CRPs nationally have created greater need for efficacy and outcome data. Discussions and metrics involving who is served through CRPs, the ways in which student success is facilitated, are going to be essential to the collegiate recovery field. Longitudinal study of intrapersonal, interpersonal, and socioecological changes, as well as recovery rates, academic measures, and professional

outcomes will also be essential in CRP programming and the establishment of efficacy measures.

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ORCID

Austin M. Brown http://orcid.org/0000-0001-9958-3696
Robert D. Ashford http://orcid.org/0000-0003-3979-1754
Brenda Curtis http://orcid.org/0000-0002-2511-3322

References

Association of Recovery in Higher Education. (2016). *Collegiate recovery program members*. Retrieved from http://collegiaterecovery.org/programs/

Bugbee, B. A., Caldeira, K. M., Soong, A. M., Vincent, K. B., & Arria, A. M. (2016). Collegiate recovery programs: A win-win proposition for students and colleges. College Park, MD: Center on Young Adult Health and Development. Available at http://www.cls.umd.edu/docs/CRP.pdf. doi:10.13140/RG.2.2.21549.08160

Cleveland, H. H., Baker, A., & Dean, L. R. (2010). Characteristics of collegiate recovery community members. In H. Cleveland, K. Harris, & R. Wiebe (Eds.), *Substance abuse recovery in college. Advancing responsible adolescent development* (pp. 37–56). Boston, MA: Springer.

Diener, E., Wirtz, D., Tov, W., Kim-Prieto, C., Choi, D. W., Oishi, S., & Biswas-Diener, R. (2010). New well-being measures: Short scales to assess flourishing and positive and negative feelings. *Social Indicators Research*, *97*(2), 143–156. doi:10.1007/s11205-009-9493-y

Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. New York, NY: NYU Press.

Granfield, R., & Cloud, W. (2001). Social context and "natural recovery": The role of social capital in the resolution of drug-associated problems. *Substance Use & Misuse*, *36*(11), 1543–1570. doi:10.1081/JA-100106963

Groshkova, T., Best, D., & White, W. (2012). The assessment of recovery capital: Properties and psychometrics of a measure of addiction recovery strengths. *Drug and Alcohol Review*, *32*(2), 187–194. doi:10.1111/dar.2013.32.issue-2

Harris, K. S., Baker, A., & Cleveland, H. H. (2010). Collegiate recovery communities: What they are and how they support recovery. In Cleveland HH, Harris KS, Wiebe RP (Eds). *Substance abuse recovery in college* (pp. 9–22). Boston (MA): Springer US.

Kimball, T. G., Shumway, S. T., Harris, K. S., & Austin-Robillard, H. (2016). Hoping and coping in recovery: A phenomenology of emerging adults in a collegiate recovery program. *Alcohol Treatment Quarterly*. *35*(1), 46–62.

Kirouac, M., Stein, E. R., Pearson, M. R., & Witkiewitz, K. (2017). Viability of the World Health Organization quality of life measure to assess changes in quality of life following treatment for alcohol use disorder. *Quality of Life Research*, *26*(11), 2987–2997.

Koohi, F., Nedjat, S., Yaseri, M., & Cheraghi, Z. (2017). Quality of life among general populations of different countries in the past 10 Years, with a focus on human development index: A systematic review and meta-analysis. Iranian Journal of Public Health, *46*, 12–22.

Laudet, A., Harris, K., Kimball, T., Winters, K., & Moberg, D. P. (2016). In college and in recovery: Reasons for joining a collegiate recovery program. *Journal of American College Health*, *64*(3), 238–246. doi:10.1080/07448481.2015.1117464

Laudet, A., Harris, K., Kimball, T., Winters, K. C., & Moberg, D. P. (2014). Collegiate recovery communities programs: What do we know and what do we need to know? *Journal of Social Work Practice in the Addictions*, *14*(1), 84–100. doi:10.1080/1533256X.2014.872015

Laudet, A. B. (2008). The road to recovery: Where are we going and how do we get there? Empirically driven conclusions and future directions for service development and research. *Substance Use & Misuse*, *43*(12/13), 2001–2020. doi:10.1080/10826080802293459

Laudet, A. B. (2011). The case for considering quality of life in addiction research and clinical practice. *Addiction Science & Clinical Practice*, *6*(1), 44–55.

Laudet, A. B., Harris, K., Kimball, T., Winters, K. C., & Moberg, D. P. (2015). Characteristics of students participating in Collegiate Recovery Programs: A national survey. *Journal of Substance Abuse Treatment*, *51*, 38–46. doi:10.1016/j.jsat.2014.11.004

Laudet, A. B., Harris, K., Winters, K., Moberg, D., & Kimball, T. (2014). Nationwide survey of collegiate recovery programs: Is there a single model? *Drug & Alcohol Dependence*, *140*, e117. doi:10.1016/j.drugalcdep.2014.02.335

Laudet, A. B., & Humphreys, K. (2013). Promoting recovery in an evolving policy context: What do we know and what do we need to know about recovery support services? *Journal of Substance Abuse Treatment*, *45*(1), 126–133. doi:10.1016/j.jsat.2013.01.009

Laudet, A. B., & White, W. L. (2008). Recovery capital as prospective predictor of sustained recovery, life satisfaction, and stress among former poly-substance users. Substance Use & Misuse, *43*(1), 27–54.

Skevington, S. M., Lotfy, M., & O'Connell, K. A. (2004). The World Health Organization's WHOQOL-BREF quality of life assessment: Psychometric properties and results of the international field trial. A report from the WHOQOL group. *Quality of Life Research*, *13* (2), 299–310. doi:10.1023/B:QURE.0000018486.91360.00

Transforming Youth Recovery. (2016). *Higher education grant programs*. Retrieved from http://www.transformingyouthrecovery.org/higher-education-grant-programs/

White, W., & Finch, A. (2006). The recovery school movement: Its history and future. *Counselor*, *7*(2), 54–57.

World Health Organization. (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychology Medicine*, *28*(3), 551–558. doi:10.1017/S0033291798006667