CANADIAN UNIVERSITY STUDENTS' EXPERIENCES OF ADDICTION RECOVERY: A PILOT STUDY

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Abstract

Addiction is a critical concern on Canadian post-secondary campuses, yet recovery remains largely overlooked. Guided by a recovery capital framework, this pilot survey explored the recovery characteristics, supports, and barriers among 101 Canadian university students (average age 24.5). Participants reflected diversity across gender (men 49.5%, women 39.6%, minoritized 10.9%), sexual orientation (LGBTQIA2S+ 46.5%), and race/ethnicity (racially minoritized 45.5%). Recovery pathways were primarily abstinence-based (59.4%), followed by non-abstinence approaches (25.7%) and those unsure (9.9%). Students reported recovering from alcohol (44.6%), cannabis (26.7%), self-harm (24.8%), nicotine (23.8%), and eating issues (21.8%). The most useful supports were individual therapy (52.5%), media (35.6%), and peer groups (33.7%). Barriers included fear of losing coping mechanisms (63.4%) and minimizing problem severity (48.5%). Most students viewed campus as recovery-threatening (68.3%) and called for more supports, particularly substance-free residence housing (74.3%) and better access to services (29.7%). Findings underscore the need for recovery-inclusive strategies in Canadian higher education.

***Keywords**:* recovery, recovery capital, higher education, addiction, campus recovery programs

Résumé

Des recherches se sont penchées sur la consommation de substances psychoactives chez les étudiants des établissements postsecondaires au Canada, mais le rétablissement en matière de dépendance demeure largement négligé. S'appuyant sur le cadre du capital de rétablissement, cette enquête pilote a examiné les caractéristiques, les soutiens et les obstacles au rétablissement de 101 étudiants universitaires canadiens (âge moyen de

24,5 ans). Les participants représentaient une diversité de genres (hommes : 49,5 %, femmes : 39,6 %, genres minoritaires : 10,9 %), d'orientations sexuelles (LGBTQIA2S+ : 46,5 %) et d'appartenances raciales ou ethniques (groupes racisés : 45,5 %). Les étudiants ont indiqué se rétablir de troubles liés à l'alcool (44,6 %), au cannabis (26,7 %), à l'automutilation (24,8 %), à la nicotine (23,8 %) et à l'alimentation (21,8 %). Les trajectoires de rétablissement comprenaient l'abstinence (59,4 %) et la réduction des méfaits (25,7 %). Les soutiens jugés les plus utiles étaient la thérapie individuelle (52,5 %), les médias (35,6 %) et les groupes de pairs (33,7 %). Les principaux obstacles comprenaient la peur de perdre des mécanismes d'adaptation (63,4 %) et la minimisation de la gravité du problème (48,5 %). La majorité des étudiants percevaient le campus comme une menace pour leur rétablissement (68,3 %) et ont exprimé le besoin de plus de soutiens, notamment de logements sans drogues et alcool (74,3 %) et d'un meilleur accès aux services existants (29,7 %). Ces résultats mettent en évidence la nécessité de développer des stratégies de santé et de bien-être qui incluent le rétablissement au sein des établissements postsecondaires canadiens.
Mots clés : rétablissement, capital de rétablissement, établissements postsecondaires, dépendance, programmes de rétablissement sur les campus

INTRODUCTION

Substance use and process addictions (e.g., gambling, eating) are critical concerns on university and college campuses (Byrne et al., 2022; Health Canada, 2023). In the United States, for example, young adults aged 18–25 experience higher incidences of substance use disorders compared to any other age group (Substance Abuse and Mental Health Services Administration, 2022). Alcohol remains the most prevalent and harmful drug for Canadian post-secondary students (Health Canada, 2023; University of British Columbia [UBC], 2022). National survey data from a sample of 19,285 students indicate that 40% engage in binge drinking at least once per month (UBC, 2022). Similarly, a national sample of 31,643 Canadian post-secondary students shows that 79% consumed alcohol in the past year, with nearly half (47%) reporting at least one harm, including hangovers, missed responsibilities, or impulsive or risky behaviours (Health Canada, 2023). Post-secondary students with process addictions experience several negative consequences, including a greater risk of attrition, poor grades, relationship breakdown, and suicidality (Esmaeelzadeh et al., 2018; Vest et al., 2021). Despite the prevalence of process addictions among post-secondary students, research remains scarce, particularly for Canadian students in recovery.

Several definitions of recovery have been advanced by researchers, practitioners, and people with lived experience. These include abstinence-focused models (Betty Ford Institute Consensus Panel, 2007) as well as non-abstinence, harm-reduction approaches (Witkiewitz et al., 2020). Importantly, recovery is understood to encompass both substance use disorders and process addictions such as eating, technology use, and gambling (Burns et al., 2024; Smith et al., 2023). While some individuals identify as being "in recovery," others resolve problematic use without adopting this identity (Kelly et al., 2018). For the purposes of this study, recovery is defined as a non-linear, multidimensional process of change through which individuals improve health and wellness, live self-directed lives, and strive to reach their full potential (Substance Abuse and Mental Health Services Administration, 2012). This understanding includes both substance and process addictions and may or may not involve abstinence.

Approximately 600,000 college students in the United States are in recovery from a substance use disorder (American College Health

Association, 2019). While no comparable Canada-wide data exists, recent survey data reported that 11% of University of Calgary students (*N* = 1,026; i.e., the site of this study) identified as being in recovery from addiction (UBC, 2022). Post-secondary environments can be threatening for students in or seeking recovery as heavy substance use is common (Burns, 2021; Byrne et al. 2022; Ford et al., 2021). Canadian post-secondary institutions have responded to substance use through preventative harm reduction programming (e.g., naloxone training and safer use supplies) and, more recently, through implementing collegiate recovery programs (CRPs; Burns et al., 2024; Park et al., 2023). Collegiate recovery program best practices include paid full-time staff, a dedicated physical space, and peer-support programming (Vest et al., 2021). Dating back to the 1970s, recent estimates suggest there are at least 138 CRPs in the United States (Vest et al., 2021). In Canada, the first CRP was established at the University of British Columbia in 2019, followed by the University of Windsor in 2020 and the University of Calgary in 2021 (Burns et al., 2024; Park et al., 2023).

The aim of CRPs is to create spaces on college and university campuses that improve recovery capital, a socio-ecological, strength-based framework that refers to the set of internal and external resources available to a person to sustain recovery (e.g., housing, coping skills, social networks and norms; Cloud & Granfield, 2008). The recovery capital model identifies three interrelated domains: personal (e.g., health, coping skills, resources for living, access to treatment), social (e.g., relationships, peer networks), and community (e.g., stigma, policies, and recovery services; Hennessy, 2017). Collegiate recovery programs bolster recovery capital through offering opportunities to build peer support and accountability, substance-free housing and events, scholarships, as well as awareness and education that reduces stigma (Vest et al., 2021; Smith et al., 2023).

To date, research on CRP students has been primarily United States-based. Two multisite, national studies (Laudet et al., 2015; Smith et al., 2023), launched nearly a decade apart, reported parallel findings, including high levels of severe polysubstance use, mental health challenges, and justice system involvement. Of note, Smith and colleagues (2023) included three cohorts (2020–2023; *N* = 334) from 43 universities and colleges across the United States and one in Ontario, Canada (University of Windsor). Students reported high levels of recovery capital and quality of life, averaging nearly four years in recovery. The number of Canadian students was not indicated, nor any Canada-specific analyses presented.

A recent case study in England focusing on university students participating in an emerging CRP (*N* = 61) found the median age of students was 22 years, with a median of eight months in recovery, and an even split between substance use and process addictions (Day & Trainor, 2024). Apart from three recent qualitative studies focusing on Canadian students and staff recovery experiences in a developing CRP (Burns et al., 2024, 2025; Park et al., 2023), little is known about the experiences of Canadian students who identify as recovering from substance use and process addictions. To address this critical gap in the literature, drawing on a recovery capital framework, this pilot study aimed to explore the following three research questions:

1. What are the characteristics of University of Calgary students who are recovering from substance use and process addictions?
2. What supports and barriers to recovery do students identify?
3. What do students in recovery recommend for creating more recovery-supportive campuses?

By exploring these questions from the perspective of recovering students, this pilot study aims to provide more person-centred, inclusive, and, ultimately, effective recovery programs in Canadian post-secondary campuses while providing opportunities for future research.

METHODOLOGY

Research Design

This pilot survey is part of a larger mixed-method study focusing a convenience sample of students at the University of Calgary who identified as (1) being in recovery, (2) not being in recovery, and/or (3) being unsure of their recovery status. This article focuses on students who identified as being in recovery (N = 101). The University of Calgary is a large, research-intensive, public university with approximately 37,400 students, including 78.6% undergraduate, 21.4% graduate, 47% men, 52.7% women, and 0.3% non-binary (University of Calgary, 2022). No student demographic information was available for ethnicity or sexual orientation. Of note, at the time of the study (2022–2023), the university began implementing a CRP, known as the University of Calgary Recovery Community (UCRC), which had limited resources and activities (e.g., one online peer support meeting). None of the participants in this study indicated that they were familiar with the UCRC. At the survey's end, participants could enter a prize draw for one of five $100 gift cards.

Measures

The survey was co-created by two of the authors and guided by Canada's Life in Recovery Survey (McQuaid et al., 2017), previous CRP survey research (Laudet et al., 2015; Smith et al., 2023), and a recovery capital framework (Cloud & Granfield, 2008; Hennessy et al., 2022). The 44-item self-reported survey included 41 closed-ended questions (e.g., yes/no, 5-point Likert scale) and three open-ended questions (i.e., reasons for seeking recovery, most helpful supports, and recommendations to make the campus more recovery-supportive). The present study reports on a subset of 23 survey items most relevant to the research questions—specifically, key demographics (e.g., age, gender, sexual orientation, race/ethnicity), recovery characteristics, motivations, barriers, and supports. Other items (e.g., GPA, student-athlete status, fraternity/sorority membership, employment) were excluded to streamline the analysis and may be explored in future work.

Demographics and Recovery Characteristics

Demographic questions included age, gender (male, female, two-spirited, unsure, other), LGBTQIA2S+ status, ethnicity, and degree program (i.e., undergraduate or graduate; see Table 1). Participants who answered a stem question indicating that they were in recovery were asked to indicate which substance/process addiction they were recovering from, using a dichotomous response format (yes/no) for an 18-item drop-down menu (nine substances, nine processes; see Table 1). Subsequently, participants were asked to select reasons for engaging in current/past substance use and process addictions from a nine-item drop-down list, barriers for seeking recovery (see Table 6), and whether they ascribe to an abstinence-based recovery model (yes/no/unsure).

Facilitators Of and Barriers to Recovery

Participants were asked if they had ever used or were currently using any supports to address their substance use and/or process addictions (yes/no). If yes, using a 10-item drop-down menu, they were asked to select the supports they had used/are currently using (e.g., mutual aid, medication-assisted, counselling, etc.), which ones were most helpful (open-ended), and whether they preferred to seek support on or off campus (yes/no). They were asked to select, from a 14-item drop-down, the main barriers to seeking recovery (e.g., performance suffering, financial cost, etc.; see Table 6). Using a 5-point Likert (1: strongly disagree, to 5: strongly agree), they were asked whether being in recovery had been a "barrier to creating social connections on campus," "how open they are with most people about their recovery," and "how much they found the university to be a drug promoting/recovery-threatening environment."

Recommendations to Improve Campus Supports

Participants were asked whether there is a need for "additional supports on campus specifically for substance use, behaviours, and recovery" (yes/no), "substance-free residence housing on campus[1]" (yes/no), and the "types of supports they would like to see on campus for substance use/behaviours and recovery" (open-ended; see Table 7).

ANALYSIS

Descriptive statistics were calculated for all variables, with continuous variables expressed as means and standard deviations and categorical variables summarized as frequencies and percentages. Before analysis, data cleaning procedures were implemented to ensure accuracy and consistency. Considering all variables except age were categorical, specific strategies were adopted for managing missing data and outliers. Cases with missing responses were excluded from calculating percentages for the respective variable (pair-wise deletion) and noted in the documentation. Infrequent categories, less than 5% of the sample**,** were either grouped with similar categories to enhance statistical power or excluded.

Additionally, univariate analyses assessed addiction recovery variables of interest by comparing subgroups across key demographic factors: gender, age, race/ethnicity, and LGBTQIA2S+ status. Gender was categorized into three groups: men, women, and minoritized gender identities, the latter including individuals who identified as non-binary, two-spirited, and unsure. Age was divided into two categories to capture key life transitions corresponding to young adulthood and adulthood, 18–25 and 26+ years old, respectively. Given the small sample size of racial and ethnic groups, race/ethnicity was dichotomized into two categories: those who self-identified as White and those from Black, Indigenous, and people of colour (BIPOC) communities. Similarly, LGBTQIA2S+ identity was dichotomized into members and non-members of the LGBTQIA2S+ community. Subgroup comparisons were conducted using chi-square and Fisher's exact tests (when the expected cell count was less than five), and family-wise Bonferroni corrections were applied to adjust for multiple comparisons: $\alpha = .0024$ for age (i.e., 21 variables; three recovery-focused variables of interest and the 18 addictions) and $\alpha = .0023$ for gender, race/ethnicity, and LGBTQIA2S (i.e., 22 variables; same variables as age plus student type).

RESULTS

Demographics and Recovery Characteristics

The sample was composed of mostly White (54.5%), male (49.5%), heterosexual, (51.5%) undergraduate (85.1%) students with a mean age of 24.5 years (*SD* = 6.4; see Table 1 for demographic details). Recovery pathways were primarily abstinence-based (59.4%), with 25.7% identifying a non-abstinence approach and 9.9% reporting they were unsure. Based on the National Institute on Alcohol Abuse and Alcoholism's temporal periods of recovery (Hagman et al., 2022), students were distributed across stages: initial (≤3 months, 23.1%), early (3 months–1 year, 24.6%), sustained (1–5 years, 38.5%), and stable (>5 years, 13.8%). Over half reported recovery from substance use (52.5%), compared to a process addiction (17.8%) or both (29.7%). The most common issues were alcohol (44.6%), cannabis (26.7%), self-harm/injury (24.8%), nicotine (23.8%), and eating concerns (21.8%).

Subgroup Differences

Gender subgroup comparisons revealed significant differences in recovery variables (see Table 2). Men primarily reported recovering from substances only (60.0%), whereas women and minoritized gender identities were more likely to report recovery from both substances and pro-

1 Substance-free housing was defined as not permitting the use of alcohol or other substances recreationally in both public and private spaces.

cess addictions (60% and 100%, respectively). Women reported higher rates of recovery from eating concerns (30%), self-harm (30.0%), and excessive exercise (20%) compared to men. Individuals with minoritized gender identities reported higher rates of recovery from eating concerns (72.7%) and self-harm (90.9%) than both men and women.

Several significant differences emerged between White and BIPOC students (see Table 4). A greater proportion of BIPOC students reported abstinence-based recovery (71.7% vs. 49.1%) and recovery from substances alone (56.5% vs. 23.6%). In contrast, White students more often reported recovery from both substance use and process addictions (65.5%) and higher rates of recovery from cocaine, prescription and recreational stimulants (e.g., methylphenidate, amphetamines, methamphetamine, MDMA), eating concerns, and self-harm.

For both age and LGBTQIA2S+ comparisons (see Tables 3 and 5), a single significant relationship emerged. Students aged 26 and older reported higher rates of recovery from opiates (9.7%) compared to those 25 and under (0%). In addition, LGBTQIA2S+ students reported significantly higher rates of recovery from self-harm (46.8%) than non-LGBTQIA2S+ students (5.8%).

Recovery Motivations, Barriers, and Supports

The most common reasons for past addictive behaviours were coping with stress (76.2%), being connected to recovery-hostile environments (68.3%), social connection (58.4%), and reducing loneliness/isolation (56.4%; see Table 6). Reported barriers to recovery included fear of losing a preferred coping mechanism (63.4%), not feeling ready or believing the problem was bad enough (48.5%), and fear of being unable to recover (46.5%; see Table 6). Most students reported using more than one recovery support or service, including professional therapy/counselling (52.5%), recovery-oriented media (35.6%), mutual aid/peer support (33.7%), and medication-assisted therapies (32.7%). While most students preferred off-campus supports (58.4%), over half (54.5%) had used on-campus services (see Table 7). A majority (66.3%) indicated that more recovery supports are needed on campus. Their suggestions for additional supports included: education and awareness on substance use and process addictions (35.6%), counselling and mental health services (29.7%), social events (17.8%), financial (9.9%), and peer support groups (5.9%). More than two-thirds (74.3%) endorsed the need for substance-free housing on campus, with 50.4% expressing interest residing in such housing.

DISCUSSION AND RECOMMENDATIONS

Recovery Characteristics and Pathways

To our knowledge, this pilot study is the first to quantitatively describe the characteristics, motivations, supports, and barriers to recovery identified by Canadian post-secondary students. Although most participants where White, male, undergraduate, and abstinent from alcohol, the sample was diverse in terms of age, gender, sexual orientation, and race/ethnicity. Relative to recovering students who were participating in CRPs surveyed in Laudet et al. (2015) and Smith et al. (2023), our sample was slightly younger (M = 24.5 vs. M = 26 and 29, respectively) and had fewer women (40% vs. 51% and 43%, respectively). The younger age and fewer women in our sample may reflect the higher proportion of undergraduate students (85%), as graduate students tend to be older, and women (Perry, 2021).

When compared to the broader University of Calgary student population, several differences emerged in our recovery sample. Institutionally, 21.4% of students are enrolled in graduate programs, whereas only 12.9% of our participants reported graduate status, suggesting that students in recovery may be underrepresented at the graduate level. This may reflect graduate students' reduced time on campus, competing academic and professional demands, or lower visibility in recovery-oriented programming. Gender distributions also diverged from insti-

tutional trends. Consistent with evidence that men typically outnumber women in recovery populations (Abreu Minero et al., 2022), men comprised 49.5% of our sample and women 39.6%. This contrasts with the broader UCalgary student population, which is 47% men, 52.7% women. Of note, 10.9% of our sample identified as minoritized genders, compared with only 0.3% of the general UCalgary student body. Although gender categories were collapsed into a single group for analysis, this overrepresentation is consistent with broader evidence suggesting that gender-diverse populations are disproportionately affected by substance use disorders and more likely to be represented within recovery communities (Rosner et al., 2021; Vázquez et al., 2022). Our sample also reflected greater diversity than prior U.S.-based studies in terms of LGBTQIA2S+ identity (46.5% vs. 40% in Smith et al., 2023) and ethnicity/race (54.5% White vs. >88% White in both Laudet et al., 2015 and Smith et al., 2023).

Recognizing this diversity among recovering students, recovery organizations and CRPs are increasingly implementing inclusive programming. For instance, the Association of Recovery in Higher Education (2024) introduced an Equity and Justice Discussion Series, while the University of British Columbia (2024) Student Recovery Community offers a weekly Queer All-Recovery Meeting. Similarly, the Soul Circle Scholarship Seminar for BIPOC students (VCU Rams in Recovery, 2024) provides BIPOC-centred virtual recovery seminars. Building on these models, universities could expand supports by developing recovery groups tailored for marginalized students (e.g., women, LGBTQIA2S+, BIPOC), ensuring diverse facilitator representation, and partnering with cultural or identity-based student associations to co-design programming. Targeted scholarships and leadership opportunities for minoritized students in recovery could further reduce financial barriers and strengthen recovery capital. Ultimately, additional research is needed to better understand how demographic identity markers shape recovery identities and pathways, including engagement with and retention in recovery supports and services.

Although most students reported an abstinence-based approach to recovery, a notable proportion did not or were unsure of their pathway. This aligns with a nationally representative U.S. study showing that 45% of individuals who resolved a substance use problem did so without abstinence (Kelly et al., 2018). Higher rates of non-abstinent recovery may be linked to the prevalence of process addictions, where complete cessation is not feasible (e.g., eating concerns), or to respondents using medication-assisted recovery models. For these students, harm reduction strategies may involve building tools and coping strategies to reduce the frequency or severity of behaviours (e.g., bingeing) rather than eliminating them entirely (Davies et al., 2022). Uncertainty about recovery identity may also reflect narrow public views that equate recovery with abstinence-based or 12-step models (Burns et al., 2024; Schoenberger et al., 2022). Broader terminology and concepts, such as "problem resolution," may be needed to capture the diversity of recovery experiences (Kelly et al., 2018).

To address this diversity of recovery pathways, universities can take several steps. Campus services and CRPs can be explicitly inclusive of both abstinence and harm-reduction–oriented students. Staff training would benefit from emphasizing language that validates multiple pathways, while student health services can integrate support for medication-assisted recovery. Peer-led groups that acknowledge both substance and process addictions can also help normalize diverse recovery experiences. Together, these measures may reduce stigma and expand access to support for students who might otherwise hesitate to identify as "in recovery" (Blyth et al., 2023, 2025).

Equally important is reconsidering traditional metrics of recovery "success," such as days abstinent. More holistic approaches, including assessments of recovery capital (e.g., coping skills, stress management, social connection), offer a fuller picture of student recovery (Hennessy et al., 2022; Vilsaint et al., 2017). Universities can implement this shift by embedding recovery capital measures into campus-wide wellness assessments, evaluating

CRP effectiveness through multiple indicators (e.g., academic engagement, social belonging, coping strategies), and sharing outcomes with students to normalize a strengths-based view of recovery. Institutions might also integrate recovery capital–based measures, such as the Multidimensional Inventory of Recovery Capital [MIRC]; Bowen et al., 2023) into strategic planning for student wellness, ensuring recovery supports are framed around well-being, growth, and resilience rather than abstinence alone.

Subgroup Differences

Our subgroup analyses of recovery pathways revealed that men were primarily recovering from substances, while women were primarily recovering from process addictions, leading with eating concerns. Of note, 100% of the students who identified as LGBTQIA2S+ were recovering from both substance and process addictions. The overrepresentation of women and sexual minorities with eating concerns may be due to societal expectations of body image not experienced by cisgendered, heterosexual men (Simon et al., 2022). Eating disorders raise additional concerns because compared to substance use, certain behaviours (e.g., dieting and glorifying thinness) are more socially normalized. This normalization may reinforce the perception of "not thinking the problem is bad enough," which participants identified as a main barrier to starting recovery.

Future research should explore effective CRP models that use recovery capital frameworks to holistically examine how multiple recovery approaches are integrated into student wellness and affairs programming, while also expanding peer support groups to address these issues. In practice, universities can respond by creating specialized peer groups for students recovering from eating disorders and self-harm, integrating body image and disordered eating awareness into wellness campaigns, and collaborating with campus counselling services to ensure staff are trained in process addiction recovery. Partnering with equity offices and student associations may further help tailor supports to women, LGBTQIA2S+ students, and other minoritized groups disproportionately affected by these concerns.

Supports and Barriers to Recovery

One of the main reasons students reported for past substance use was coping with stress, while the most common barrier to seeking recovery was fear of losing a preferred coping mechanism. University life is known to be inherently stressful, as students undergo numerous life transitions and face new stressors, including academic pressures, social challenges, financial concerns, and the demands of living independently for the first time (Hennessy et al., 2021). Without adequate skills in emotional regulation, stress management, and healthy coping, students may use substances to manage these pressures (Vest et al., 2021). Consistent with this, participants identified professional therapy as the most helpful recovery support, yet many reported a preference for accessing services off campus. This may reflect concerns about stigma surrounding addiction and recovery in academic settings, which can prevent disclosure and help-seeking (Burns, 2021; Burns et al., 2021, 2025; Romo et al., 2012). These findings suggest a need for more accessible, recovery-informed professional supports both on and off campus, where students can address the roots of their addiction.

Practical steps universities could take include embedding recovery-informed counselling within existing student wellness centres, expanding confidential online or hybrid therapy options, and building partnerships with community-based providers to reduce wait times and stigma concerns. Training campus counsellors and advisors in recovery literacy, such as recovery ally trainings (Recovery on Campus, 2025a), would further ensure students receive consistent, non-judgemental support when seeking help. Finally, integrating stress management and healthy coping skill development into orientation and first-year transition programming may reduce reliance on substances as primary coping mechanisms.

Most students in our sample were recovering from alcohol, which aligns with national data suggesting alcohol is the most prevalent and harmful drug used among post-secondary students in Canada and the United States (Health Canada, 2023, Smith et al., 2023; UBC, 2022). Further, echoing national Canadian recovery data (McQuaid et al., 2017), a main barrier to help-seeking and recovery was identified as "not feeling ready/not thinking the problem was bad enough." When drinking to excess is normalized, as is common on post-secondary campuses, it can mask problematic use and prevent help-seeking, thus reducing recovery capital (Burns, 2021; Romo et al., 2012). However, it is encouraging to see a cultural shift toward the Sober Curious and positive sobriety movements, including the rising popularity of dry bars and mocktails, which has helped normalize not drinking in social spaces (Andrews, 2024). Relatedly, the frequent use of recovery-oriented media speaks to the importance of using various social media channels (e.g., Instagram, Tiktok; Russell et al., 2022) to challenge alcohol norms and promote positive recovery messaging, which in turn helps to bolster community recovery capital.

Over half of participants also expressed a need for substance-free residence housing and would consider living there. Since conducting this survey, the University of Calgary has implemented a 12-unit substance-free housing complex for students who are in recovery and/or choose to lead a substance-free lifestyle, which helps to normalize sobriety (Banister et al., 2019). Universities can build on these promising shifts by embedding alcohol harm reduction and recovery-supportive messaging into campus-wide campaigns, ensuring substance-free social events are integrated into orientation and student life programming, and adopting policies that provide visible alternatives to alcohol-centric events. Partnering with student unions and campus bars to promote mocktails and alcohol-free spaces can also help normalize sobriety and reduce stigma. Finally, findings from this study speak to the need for institutional investments in substance-free housing, with priority access for students in or seeking recovery, and paired with educational programming that reinforces community recovery capital.

Scaling Recovery-Supportive Campuses

Recognizing many of the challenges identified in this study, such as limited recovery supports and the need for inclusive, multiple-pathway approaches, the University of Calgary established the University of Calgary Recovery Community (UCRC) in 2021 as a dedicated hub for direct recovery support, education, and advocacy. The UCRC offers peer-led support meetings, scholarships for students in recovery, substance-free housing options, drop-in programming, and recovery ally training, among other initiatives designed to foster belonging and visibility for people in recovery on campus.

In 2022, the UCRC received funding from the Government of Alberta to scale recovery-supportive programming across all 26 publicly funded post-secondary institutions in the province. This expansion led to the creation of Recovery on Campus Alberta (ROC), a provincial initiative that builds on the UCRC model to strengthen recovery-friendly environments throughout the post-secondary system. The UCRC now serves as the administrative and research hub for ROC, providing coordination, training, and evaluation support to partner campuses.

A central feature of this provincial initiative is the Recovery-Friendly Campus Pledge (Glen, 2025; Kaufman, 2024; Recovery on Campus, 2025b), which outlines eight criteria to guide institutions in reducing stigma, normalizing and celebrating recovery, and ensuring that all recovery pathways are recognized and supported. As of 2025, four Alberta institutions have signed the pledge, demonstrating institutional commitment to creating recovery-supportive environments.

The findings of this pilot study reinforce the importance of such system-level initiatives. Other post-secondary institutions may benefit from adopting the Recovery-Friendly Campus Pledge or similar frameworks to embed peer-centred, inclusive, and multi-pathway supports within their campus culture. Clearly, to enhance all dimensions of recovery capital, more personal, social, community, and policy-level initiatives are needed within post-secondary

institutions. Recovering students, a historically equity-denied group, are deserving of a safe place to live, study, play, and thrive.

Limitations

As an exploratory pilot, this study provides an important first look at the characteristics and needs of students in recovery within a Canadian post-secondary context. Conducted at a large university in western Canada, the study offers valuable baseline data to inform future multi-site and longitudinal research on recovery in higher education. While these findings may not be generalizable to all institutions, they highlight key demographic and contextual trends that can guide program development and policy.

The pilot sample represented a small proportion of the overall student population, limiting subgroup analyses. International student status was not collected, an oversight that has been corrected in the full study to enable comparison between domestic and international students. In addition, the dichotomization of race/ethnicity and LGBTQIA2S+ membership, while guided by statistical and theoretical considerations, may have obscured within-group diversity and intersectional experiences. The study also focused on recovery characteristics rather than addiction severity or harms (e.g., binge drinking frequency), which future research should include to capture the full spectrum of use and recovery trajectories. Longitudinal designs are also needed to establish temporal associations among demographics, supports, barriers, and recovery outcomes. Despite these limitations, this pilot lays essential groundwork for understanding recovery in Canadian post-secondary settings and provides an empirical foundation for expanding recovery-friendly campus initiatives nationwide.

CONCLUSION

This pilot study of Canadian post-secondary students in recovery from addiction highlights key characteristics while demonstrating the unmet needs of this diverse population. Attention to enhancing our CRP infrastructure and building existing partnerships has the potential to improve students' academic outcomes and life beyond the university. This study also provides many starting points for future research. Specifically, we have identified several additional questions to include in our larger-scale, province-wide survey, including validated measures of recovery capital, severity of use indicators, stigma, disclosure, discrimination, and general mental health and well-being. By acknowledging the significance of recovery, post-secondary institutions can demonstrate their commitment to providing an inclusive and supportive environment that addresses the diverse needs of the campus community.

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TABLES

Table 1
Complete Sample Characteristics (N = 101)

Variable	Response	% of Total (*N* = 101)
Age M (SD) = 24.5 (6.4)		
*Gender identity**	Male	49.5
	Female	39.6
	Non-binary	8.9
	Two-spirited	1.0
	Unsure	1.0
*LGBTQ2S+**	Member	46.5
	Non-member	51.5
	Unsure	2.0
*Race/ethnicity**	Arab/Middle Eastern/North African	1.0
	East Asian	2.0
	South Asian	6.9
	Southeast Asian	3.0
	Black	23.8
	Biracial or multiracial	2.0
	Indigenous	2.0
	Latinx	5.0
	White	54.5
	Other	1.0
*Student type**	Undergraduate	85.1
	Graduate	12.9
*Abstinence-based recovery**	Yes	59.4
	No	25.7
	Unsure	9.9
*Recovery stage**	Initial (up to 3 months)	23.1
	Early (3 months–1 year)	24.6
	Sustained (1–5 years)	38.5
	Stable (> 5 years)	13.8
*Recovery addiction type**	Substance	52.5
	Process	17.8
	Both	29.7

Variable	Response	% of Total (*N* = 101)
*SUPs in recovery from**	Alcohol	44.6
	Cannabis	26.7
	Nicotine	23.8
	Caffeine	5
	Cocaine	8.9
	Stimulants	9.9
	Opioids	4
	Benzodiazepines	6.9
	Inhalants	1
	Eating concerns	21.8
	Exercise	10.9
	Self-harm	24.8
	Sex/Love	9.9
	Gaming	3
	Gambling	1
	Shopping	4
	Internet	7.9
	Work/Activity	2

*Note. *Values may not reflect the entire sample population as questions could be left blank* **and/or** *multiple selections could be made. Percentages (%) represent values of responses in relation to the entire sample (N = 101).*

Table 2
Gender Subgroup Comparisons

Variable	Response	% Males (*n* = 50)	% Females (*n* = 40)	% Minoritized Genders (*n* = 11)	X^2	*p*
*Student type**	Undergraduate	90	87.5	72.7	0.15[a]	.927
	Graduate	10	12.5	27.3		
*Abstinence-based recovery**	Yes	72	45	54.5	9.20[a]	.042
	No	18	35	27.3		
	Unsure	4	15	18.2		
*Recovery stage**	Initial	18	12.5	9.1	9.22[a]	.141
	Early	6	25	27.3		
	Sustained	14	30	54.5		
	Stable	2	17.5	9.1		
*Recovery addiction type**	Substance	60	22.5	0	26.81[a]	**<.001**
	Process	12	15	0		
	Both	28	60	100		
*Substances recovered from**	Alcohol	46	37.5	63.6	1.55	.461
	Cannabis	34	15	36.4	4.35[a]	.106
	Nicotine	20	25	36.4	1.25	.569
	Caffeine	4	5	9.1	0.96[a]	.675
	Cocaine	2	15	18.2	6.44[a]	.035
	Stimulants	4	12.5	27.3	5.35[a]	.054
	Opioids	2	7.5	0	1.80[a]	.450
	Benzodiazepines	2	10	18.2	4.66[a]	.090
	Inhalants	0	2.5	0	2.03[a]	.505
*Processes recovered from**	Eating concerns	4	30	72.7	24.80[a]	**<.001**
	Exercise	2	20	18.2	8.87[a]	**<.001**
	Self-harm	6	30	90.9	30.18[a]	**<.001**
	Sex/Love	8	10	18.2	1.18[a]	.583
	Gaming	4	0	9.1	2.83[a]	.233
	Gambling	0	2.5	0	2.03[a]	.505
	Shopping	0	10	0	5.23[a]	.057
	Internet	10	2.5	18.2	3.34[a]	.157
	Work/Activity	2	0	9.1	3.02	.225

Note. N = 101.
Values may not reflect the entire sample population as questions could be left blank* **and/or *multiple selections could be made. Percentages (%) represent values of responses in relation to that group/column. Bold denotes significance after correcting for multiple comparisons (α = .0023).*
[a] *Fisher's Exact test was used as expected cell counts were less than 5.*

Table 3
Age Subgroup Comparisons

Variable	Response	% 18–25 Years (*n* = 70)	% 26+ Years (*n* = 31)	X^2	*p*
*Abstinence-based recovery**	Yes	65.7	38.7	5.50	.064
	No	24.3	29		
	Unsure	5.7	16.1		
*Recovery stage**	Initial	12.9	19.4	4.88	.181
	Early	18.6	9.7		
	Sustained	20	35.5		
	Stable	4.3	16.1		
*Recovery addiction type**	Substance	47.1	16.1	7.38	.025
	Process	11.4	9.7		
	Both	41.4	61.3		
*Substances recovered from**	Alcohol	41.4	48.4	1.57	.210
	Cannabis	20	35.5	4.38	.036
	Nicotine	27.1	16.1	0.78	.378
	Caffeine	4.3	6.5	0.39	.533
	Cocaine	7.1	12.9	1.36	.243
	Stimulants	7.1	12.9	1.36	.243
	Opioids	0	9.7	8.03	**.005**
	Benzodiazepines	8.6	3.2	0.69	.406
	Inhalants	0	3.2	2.62	.106
*Processes recovered from**	Eating concerns	20	22.6	0.40	.525
	Exercise	10	9.7	0.03	.872
	Self-harm	25.7	19.4	0.13	.721
	Sex/Love	7.1	16.1	2.73	.099
	Gaming	2.9	3.2	0.05	.829
	Gambling	0	3.2	2.62	.106
	Shopping	1.4	9.7	4.62	.032
	Internet	11.4	0	3.36	.067
	Work/Activity	1.4	3.2	0.50	.480

Note. *N* = 101.
*Values may not reflect the entire sample population as questions could be left blank **and/or** multiple selections could be made. Percentages (%) represent values of responses in relation to that group/column. Bold denotes significance after correcting for multiple comparisons (α = .0024).
[a] Fisher's Exact test was used as expected cell counts were less than 5.

Table 4
Race and Ethnicity Subgroup Comparisons

Variable	Response	% White (n = 55)	% BIPOC (n = 46)	X^2	p
*Student type**	Undergraduate	81.8	89.1	0.38	.568
	Graduate	14.5	10.9		
Abstinence-based recovery*	Yes	49.1	71.7	7.64[a]	**.019**
	No	36.4	13		
	Unsure	10.9	8.7		
*Recovery stage**	Initial	18.2	10.9	0.48[a]	.962
	Early	20	10.9		
	Sustained	32.7	15.2		
	Stable	12.7	4.3		
*Recovery addiction type**	Substance	23.6	56.5	13.32[a]	**<.001**
	Process	10.9	13		
	Both	65.5	30.4		
*Substances recovered from**	Alcohol	43.6	45.7	0.04	.844
	Cannabis	29.1	23.9	0.34	.654
	Nicotine	27.3	19.6	0.82	.362
	Caffeine	5.5	4.3	0.07[a]	.798
	Cocaine	16.4	0	8.26[a]	**.004**
	Stimulants	16.4	2.2	5.65[a]	**.020**
	Opioids	7.3	0	3.48[a]	.123
	Benzodiazepines	9.1	4.3	0.87[a]	.299
	Inhalants	1.8	0	0.85[a]	.545
*Processes recovered from**	Eating concerns	30.9	10.9	5.90[a]	**.017**
	Exercise	16.4	4.3	3.73[a]	.062
	Self-harm	36.4	10.9	8.74[a]	**.005**
	Sex/Love	9.1	10.9	0.89[a]	.511
	Gaming	3.6	2.2	0.19[a]	.666
	Gambling	0	2.2	1.21[a]	.455
	Shopping	7.3	0	3.48[a]	.123
	Internet	3.6	13	3.04[a]	.137
	Work/Activity	3.6	0	1.71[a]	.499

Note. N = 101.
Values may not reflect the entire sample population as questions could be left blank* **and/or *multiple selections could be made. Percentages (%) represent values of responses in relation to that group/column. Bold denotes significance after correcting for multiple comparisons (α = .0023).*
[a] *Fisher's Exact test was used as expected cell counts were less than 5.*

Table 5
LGBTQIA2S+ Subgroup Comparisons

Variable	Response	% LGBTQIA2S+ (n = 47)	% Non-LGBTQIA2S+ (n = 52)	X^2	p
*Student type**	Undergraduate	91.5	82.7	5.33[a]	.568
	Graduate	8.5	15.4		
*Abstinence-based recovery**	Yes	59.6	61.5	3.17[a]	.631
	No	23.4	26.9		
	Unsure	10.6	9.6		
*Recovery stage**	Initial	6.4	21.2	8.34[a]	.159
	Early	17	15.4		
	Sustained	25.5	25		
	Stable	12.8	5.8		
*Recovery addiction type**	Substance	34	42.3	5.28[a]	.202
	Process	6.4	17.3		
	Both	59.6	40.4		
*Substances recovered from**	Alcohol	48.9	40.4	1.01[a]	.712
	Cannabis	23.4	28.8	1.34[a]	.525
	Nicotine	31.9	17.3	3.13[a]	.174
	Caffeine	4.3	3.8	5.20[a]	.149
	Cocaine	12.8	5.8	1.82[a]	.421
	Stimulants	14.9	5.8	2.53[a]	.339
	Opioids	8.5	0	5.25[a]	.122
	Benzodiazepines	8.5	5.8	0.87[a]	.745
	Inhalants	2.1	0	3.23[a]	.485
*Processes recovered from**	Eating concerns	31.9	13.5	5.05[a]	.094
	Exercise	14.9	7.7	1.58[a]	.478
	Self-harm	46.8	5.8	23.40[a]	<.001
	Sex/Love	8.5	11.5	0.61[a]	.792
	Gaming	2.1	3.8	1.51[a]	.829
	Gambling	2.1	0	3.23[a]	.485
	Shopping	8.5	0	5.25[a]	.122
	Internet	4.3	11.5	2.12[a]	.385
	Work/Activity	4.3	0	3.41[a]	.253

Note. N = 101. Participants who marked unsure were excluded from this analysis (n = 4).
Values may not reflect the entire sample population as questions could be left blank* **and/or *multiple selections could be made. Percentages (%) represent values of responses in relation to that group/column. Bold denotes significance after correcting for multiple comparisons (α = .0023).*
[a] *Fisher's Exact test was used as expected cell counts were less than 5.*

Table 6
Participant Selections for Past Reasons for Use and Barriers to Recovery

Variables	Response	% of Total (*N* = 101)
*Reasons for SUPS**	Coping with stress	76.2
	Social connection	58.4
	Loneliness/Isolation	56.4
	Fun	46.5
	Social norms/Cultural influences	44.6
	Pain relief	43.6
	Peer-pressure	38.6
	Performance enhancement	25.7
	Unsure	4.0
*Barriers to seeking recovery**	Recovery hostile environments	68.3
	Losing my preferred coping mechanism	63.4
	Not feeling ready/Thought problem not bad enough	48.5
	Fear that I wouldn't be able to recover	46.5
	Feeling ashamed/Self-stigma	45.5
	No longer knowing how to have fun	44.6
	Not knowing where to go for help	44.6
	Fear of what other people would think	36.6
	Financial barriers to accessing supports	27.2
	Losing my social network	26.7
	Performance suffering	24.8
	Experiencing peer pressure	24.8
	Weary of long wait times to accessing supports	24.8
	Unsure	5.0

Note. N = 101.
**Multiple selections could be made for each variable. Percentages (%) represent individual selections in relation to the total sample.*

Table 7
Participant Selections for Supports/Services Utilized, and Recommended Supports

Variables	Response	% of Total (*N* = 101)
*Recovery supports/ Services utilized**	Off-campus supports	58.4
	On-campus supports	54.5
	Professional therapy or counselling	52.5
	Recovery-oriented media	35.6
	Mutual-aid peer support	33.7
	Medication-assisted	32.7
	Recovery coaching	24.8
	Moderation management	23.8
	Inpatient treatment	23.8
	Detox centre	18.8
	Outpatient treatment	17.8
	None (non-assisted recovery)	16.8
*Recommended supports**	Substance-free housing (interest*)	74.3(50.4%*)
	On-campus supports (general)	66.3
	Stigma-reduction programming	35.6
	Counselling	29.7
	Social events (substance-free)	17.8
	Financial	9.9
	Peer-support groups	5.9

Note. N = 101.
**Multiple selections could be made for each variable. Percentages (%) represent individual selections in relation to the total sample.*