

Title Registration for a Systematic Review: Recovery Schools for Improving Well-Being among Students in Recovery from Substance Use: A Systematic Review

Emily A. Hennessy, Emily E. Tanner-Smith, Andrew J. Finch, Nila A. Sathe, & Shannon A. Potter

Submitted to the Coordinating Group of:

<input type="checkbox"/>	Crime and Justice
<input checked="" type="checkbox"/>	Education
<input type="checkbox"/>	Disability
<input type="checkbox"/>	International Development
<input type="checkbox"/>	Nutrition
<input checked="" type="checkbox"/>	Social Welfare
<input type="checkbox"/>	Other:

Plans to co-register:

<input checked="" type="checkbox"/>	No		
<input type="checkbox"/>	Yes	<input type="checkbox"/> Cochrane	<input type="checkbox"/> Other
<input type="checkbox"/>	Maybe		

Date Submitted: 20 April 2016

Date Revision Submitted: 27 June 2016

Approval Date: 17 July 2016

Publication Date: 01 September 2016

TITLE OF THE REVIEW

Recovery Schools for Improving Well-Being among Students in Recovery from Substance Use: A Systematic Review

BACKGROUND

Youth Substance Use Disorders

Substance use disorders (SUDs) among youth are a major public health problem. In the United States, for example, the incidence of SUDs increases steadily after age 12 and peaks among youth ages 18-23 (White, Evans, Ali, Abrahams, & King, 2009). Although not every youth who experiments with alcohol or illicit drugs is diagnosed with a SUD, approximately 7-9% of 12-24 year olds in the United States were admitted for public SUD treatment in 2013 (SAMHSA, 2016). The true prevalence of SUDs among youth in the United States is likely higher than 7-9%, however, given that many youth receive treatment in private or in non-specialty settings (Laudet, Harris, Kimball, Winters, & Moberg, 2014), and other youth with SUDs may never receive treatment for their substance use problems (SAMHSA, 2015). Data available on substance use patterns and treatment availability in other nations also suggests that there are significant numbers of youth worldwide in need of some form of substance use treatment or aftercare, although this research is primarily limited to developed nations. For example, in Australia, adolescents aged 10-19 years old comprised approximately 12% of all treatment admissions from 2012-2013 (Australian Institute of Health and Welfare, Canberra, 2014). Similarly, the European Council estimated that across surveyed countries, youth constituted anywhere from 16% (Italy) to 65% (Czech Republic) of the overall substance use treatment population (Council of Europe, Pompidou Group, 2006). And, in 2011, approximately 28,000 adolescents were newly admitted to outpatient treatment across Europe (European Monitoring Centre for Drugs and Drug Addiction, 2013).

Substance use problems can have numerous detrimental consequences on the academic, social, and general well-being of youth. This might include negative effects on school or work performance, legal problems, and substance use tolerance and progression (APA, 2013). Prior research has documented the multiple negative effects from prolonged and heavy substance use, including diminished memory and cognitive abilities, reduced grades, a decreased likelihood of finishing high school or attending post-secondary education, problems attaining or keeping employment, illness, poverty, and family and social problems (Brown & Tapert, 2004; Homel, Thompson, & Leadbeater, 2014; Larm, Hodgins, Larsson, Samuelson, & Tengström, 2008; Lisdahl, Wright, Kirchner-Medina, Maple, & Shollen, 2014; Menasco & Blair, 2014; Newcomb & Bentler, 1988; Patrick, Schulenberg, & O'Malley, 2013; Squeglia, Jacobus, & Tapert, 2009; Thoma et al., 2011). Given the numerous negative effects associated with heavy substance use among youth, it is important to understand what programs and interventions might be effective in assisting youth with SUDs.

Approaches for Addressing Youth in Recovery from Substance Use Disorders

For youth diagnosed with a SUD there are a variety of adolescent-specific treatment options available, which fall within a spectrum of varying intensity from early intervention to intensive inpatient treatment (ASAM, 2013). However, SUDs are often experienced as chronic conditions; thus, multiple treatment episodes and ongoing recovery supports after treatment are often necessary to assist with the recovery process (Brown, D'Amico, McCarthy, & Tapert, 2001; Ramo, Prince, Roesch, & Brown, 2012; White et al., 2004). Indeed, research has demonstrated that youth seeking SUD treatment do not always engage in or successfully complete that treatment (Kaminer, Burlison, Burke, & Litt, 2014; Pugatch, Knight, McGuinness, Sherritt, & Levy, 2014; Winters, Stinchfield, Latimer, & Lee, 2007). Among youth that do successfully complete substance use treatment programs, large proportions return to rates of previous substance use within months of treatment discharge (Brown, et al., 2001; Ramo et al., 2012; White et al., 2004). These high rates of relapse after substance use treatment suggest the need for ongoing recovery supports after youth have been discharged from formal substance use treatment programs.

Youth with a SUD require developmentally appropriate, sustained, and multi-pronged intervention and follow-up support (Gonzales, Anglin, Beattie, Ong, & Glik, 2012). To this end, research has demonstrated the importance of structured continuing care supports after treatment for youth in recovery from substance use. These continuing care supports can include, for instance, a dedicated case manager, home visits, meetings with caregivers, or other environmental supports for the youth and their family (Godley, Godley, Dennis, Funk, Passetti, & Petry, 2014; Stanger, Ryan, Scherer, Norton, & Budney, 2015; Tanner-Smith, Wilson, & Lipsey, 2013). Indeed, youth who engage in recovery supports posttreatment have the greatest likelihood of abstinence from substance use (Brown et al., 2001; Hennessy & Fisher, 2015). Engagement in substance-free peer environments is one recovery support system that shows particular promise, and has been linked to reduced substance use and positive recovery outcomes among youth (Anderson, Ramo, Cummins, & Brown, 2010; Anderson, Ramo, Schulte, Cummins, & Brown, 2008; Mason, Mennis, Linker, Bares, & Zaharakis, 2014; Nelson, Henderson, & Lackey, 2015; Terrion, 2012).

The Importance of Schools in the Recovery Process

Success and engagement at school and in postsecondary education are critical to healthy youth development. For youth in recovery from SUDs, school attendance, engagement, and achievement build human capital by motivating personal growth, creating new opportunities and social networks, and increasing life satisfaction and meaning (Keane, 2011; Terrion, 2012; 2014). Upon discharge from formal substance use treatment settings, schools become one of the most important social environments in the lives of youth with SUDs. Healthy school peer environments can enable youth to replace substance use behaviors and norms with healthy activities and prosocial, sober peers.

Unfortunately, however, some of the most significant risk factors for substance use are embedded within school environments, including perceived peer use, association with substance-using peers, alcohol or drug availability, and academic challenges (Derzon, 2007; Mason et al., 2014; Svensson, 2000; Wambeam, Canen, Linkenbach, & Otto, 2014). Indeed, in a nationwide survey of high school students in the United States, 25.6% of respondents were offered, sold, or given an illicit drug on school property (CDC, 2011). This trend is especially problematic for youth in recovery from substance use disorders: for example, in a study of recovering youth, almost all adolescents who returned to their old school after treatment reported being offered drugs on their first day back in high school (Spear & Skala, 1995). College students suffer similar environmental risks, particularly given the high rates of, and social norms that approve of alcohol consumption on campus. For example, a study of seven universities in Great Britain demonstrated that approximately 70% of enrolled youth reported heavy drinking at least once during the previous two weeks. Across five New Zealand Universities, 37% of student respondents reported at least one binge drinking episode during the previous week and approximately 68% scored in the hazardous drinking range on the Alcohol Use Disorders Identification Test (AUDIT) consumption scale (Kypri, Paschall, Langley, Baxter, Cashell-Smith, & Bourdeau, 2009). In the United States, approximately 35-39% of college students reported binge drinking (i.e., five or more drinks in one sitting) at least once in the past month (Monitoring the Future, 2013; SAMHSA, 2013). Indeed, approximately one-half of substance use treatment admissions for college students in the United States were for alcohol use (Center for Behavioral Health Statistics and Quality, 2012). As a result of the prevalence of binge drinking and the social acceptability of alcohol consumption among college students, the college environment has been described as “abstinence hostile” for youth in recovery (Cleveland, Harris, Baker, Herbert, & Dean, 2007).

Recovery Schools as Interventions to Improve Students’ Well-Being

Given the many social and environmental challenges faced by youth in recovery from substance use, recovery-specific institutional supports are increasingly being used in educational settings. The two primary types of education-based continuing care supports for youth in recovery are recovery high schools (RHS) and collegiate recovery communities or programs (CRC). United States Federal offices have recently recognized these two educational programs as viable supports for youth after they complete formal substance use treatment programs (NIDA, 2014; ONDCP, 2014).

Recovery High Schools. The RHS model addresses academic advancement and recovery maintenance among adolescents that have completed treatment for a SUD and are still seeking to complete their high school education (Finch & Frieden, 2014). First instituted in 1979, RHSs are now located in multiple cities across the United States and are typically small, with school size on average around 30-40 students (Ruben, 2002; White & Finch, 2006). According to the Association of Recovery Schools (ARS), a national United States-based organization, there are currently 36 recovery high schools in operation in the United

States (ARS, 2016), although there have been as many as 84 operating over the past 30 years (Finch, Karakos, & Hennessy, 2016). Depending on the location and policies of the educational system in which it is embedded, an RHS may be free of charge for students or provide scholarships for tuition (Finch et al., 2015). Although RHSs are implemented using a variety of models (Moberg, Finch, & Krupp, 2014), all RHSs share a set of common characteristics. The RHS's primary purpose is to educate youth in recovery from substance use or co-occurring disorders (ARS, 2013). In addition, RHSs have two primary foci: (1) an educational focus, which includes meeting state requirements for awarding a secondary school diploma; (2) a recovery focus that ensures that all students enrolled at the school are in recovery for substance use or co-occurring disorders and that they work toward maintaining recovery while enrolled. Finally, RHSs should be available to any student who is in recovery and who would meet state or district eligibility for attendance.

Academics are a primary focus in RHSs, however, the schools also incorporate recovery-specific elements into the day, such as a daily group check-in, community service, and individual counseling sessions. Most schools have admission criteria that require some formal SUD treatment and a desire to remain abstinent. These criteria, along with structured and supervised learning, foster a recovery-supportive culture where students and staff attend to academic development and recovery maintenance. Thus, the characteristics that distinguish RHSs from traditional high schools include attention to maintenance of a positive peer culture and explicit therapeutic support (Tanner-Smith et al., 2014). Because peer substance use is highly predictive of one's own substance use (Lewis & Mobley, 2010), the peer environment of RHSs is especially important to the RHS model. Research has demonstrated that students in RHSs do feel supported by peers in the RHS setting (Karakos, 2014), and that RHSs may be effective in promoting the health and well-being of students (Finch et al., 2014; Kochanek, 2008; Moberg, Finch, Winters, & Lipsey, 2013; Moberg et al., 2014).

Collegiate Recovery Communities or Programs. As a result of the substance use environment on college campuses, CRCs have been instituted on at least 75 college campuses to provide college students with recovery supports and a social environment that encourages abstinence (Harris, Kimball, Casiraghi, & Maison, 2014). Recent data suggests that as many as 600 students are members of CRCs in the United States every academic year (Laudet et al., 2014). Given that students are typically members of CRCs for a relatively short amount of time (i.e., their duration in college), there is a likely possibility that a large proportion of college enrolled youth in recovery spend time in these communities; thus, the number of unique student members is likely much higher than 600.

Similar to RHSs, CRCs are typically small communities and range in size from 5-80 students (Cleveland et al., 2007). The CRC model incorporates multiple types of supports including recovery, educational, and peer and family support, as well as linkages to community supports and services (Harris, Baker, Kimball, & Shumway, 2008; Laudet et al., 2014). CRCs differ from RHSs, however, in that although they offer educational supports, they do not

usually offer separate academic classes for students in recovery. They primarily provide recovery support services including offering group meetings and individual counseling services, providing dedicated space for students in recovery to meet, organizing sober events and community service activities, and educating the broader community in an effort to reduce stigma around addiction (ARHE, 2015; Cleveland et al., 2007; Harris et al., 2014; Perron et al., 2011). They also may offer scholarships toward university fees and provide substance-free, supervised dormitories (Cleveland et al., 2007; Harris et al., 2014).

Theory of Change. RHSs and CRCs seek to build upon the social connectedness contained within the educational environment (Finch & Frieden, 2014). The recovery school model draws heavily on the notion of social capital, or the “amount of connectedness, social support, social control, information, and access to resources available to a person,” as one of the strongest factors influencing educational and recovery outcomes (Coleman, 1988; Granfield & Cloud, 2004; Meier, 1999). Connectedness between youth, family, peers, school, and community generates social capital and can potentially translate into academic achievement for youth (Meier, 1999).

RHSs support the recovery and academic achievement of students by fostering connectedness and social capital in a context that presents a clear pathway to success. They also provide a safe environment for youth in recovery to practice the skills learned in treatment, engage with their own physiological responses they previously avoided through substance use, and to model the positive behaviors of sober peers and mentors (Finch & Frieden, 2014). The primary elements through which this underlying theory of change is operationalized are: build a richer base of peer and family connection, social support, and accountability; minimize contact with negative peers to increase school engagement and reduce relapse risk; provide students the opportunity to meet peers in recovery and to incorporate skills learned in treatment; quickly respond to problematic behaviors or symptoms of a co-occurring disorder due to the small school environment and specialized school staff; promote contact with positive peers and adults outside school by requiring participation in support groups after school; and support graduation from high school by providing an accredited curriculum taught by licensed teachers (Tanner-Smith et al., 2014).

Similar to RHSs, CRCs also support students’ academic goals through fostering a positive, sober peer environment that provides companionship as well as emotional and recovery social support (Harris et al., 2014). Youth in recovery who choose to enroll in secondary education have additional tasks that can challenge their recovery. For example, unlike youth attending high school, youth in college are tasked with finding their own network of social support and developing healthy peer relationships, moving away from home and learning to live outside of their caregiver’s supervision, and setting and attaining educational and career goals (Harris et al., 2008). For youth in recovery, these tasks must be undertaken with the added pressure of finding a sober peer environment that supports abstinence, a difficult task in an abstinence-hostile environment. Thus, CRCs must create an internal community of recovery support, advocate for sobriety among the larger community, and support students

as they transition to young adulthood. CRCs are vital environmental supports for youth in recovery wishing to attend postsecondary education: indeed, in a recent survey of students in 29 CRCs across the United States, one-third of respondents stated they would not have chosen to attend higher education without a campus recovery support system (Laudet, Harris, Kimball, Winters, & Moberg, 2016).

OBJECTIVES

Recovery school programs in the United States are now operated with a substantial infrastructure and both private and government funding are made available for these supports (Finch et al., 2016; Moberg & Finch, 2007; Oser et al., 2016). Globally, there is also increasing attention to building more comprehensive, developmentally-appropriate continuing care supports to break the cycle of relapse and return to treatment many youth experience (Daddow & Broome, 2010; Sussman, 2010; White, Kelly, & Roth, 2012). Given the limited education and public health resources, and continued implementation of new recovery school programs (ARS, 2016; White & Finch, 2006), it would seem timely for a review of this nature, even if currently there is a somewhat limited incidence of these education-based programs compared to, for example, youth treatment programs.

Thus, the objectives of the review are to summarize and synthesize the available research evidence on the effects of recovery schools for improving academic success and social and emotional well-being among high-school and college students who are in recovery from substance use. The specific research questions guiding the review are:

1. What effect does recovery school attendance (versus attending a non-recovery or traditional school setting) have on academic outcomes for students in recovery from substance use? Specifically, what are the effects on measures of academic achievement, high school completion, college enrollment, and college completion?
2. What effect does recovery school attendance have on substance use outcomes for students in recovery from substance use? Specifically, what are the effects on alcohol, marijuana, cocaine, or other substance use?
3. Do the effects of recovery schools on students' outcomes vary according to the race/ethnicity, gender, or socioeconomic status of the students?
4. Do the effects of recovery schools on students' outcomes vary according to existing mental health comorbidity status or juvenile justice involvement of the students?

EXISTING REVIEWS

To our knowledge, no reviews of CRCs exist in the literature. Further, there is only one systematic review to date that has included findings from RHSs (Fisher, 2014). That systematic review identified a range of adolescent-specific continuing care supports, however, and did not solely focus on RHSs. In addition, although four studies of RHSs were identified in the review, the author had limited resources with which to conduct the review and a meta-analysis was not attempted. Since that review was completed, we are aware of at least three additional primary studies that would be potentially eligible for a review of RHSs, as well as multiple studies of CRCs that have never been reviewed or synthesized.

Other reviews on adolescent treatment and recovery have compared the effectiveness of different adolescent outpatient treatments (Tanner-Smith et al., 2013; Waldron & Turner, 2008), reviewed adolescent participation in 12-Step programs (Kelly & Myers, 2007; Sussman, 2010) and the role of social support in collegiate recovery programs (Smock, Baker, Harris, & D'Sauza, 2011), and explored the relationship between 12-Step attendance and adolescent substance use outcomes posttreatment (Hennessy & Fisher, 2015). Although these reviews have highlighted the importance of treatment and support programs for youth with SUDs, they have not focused explicitly on examining the potential effectiveness of recovery schools. Thus, there is a need to understand the effects of education-based interventions in light of our understanding of other youth recovery supports especially given the recent enthusiasm for their implementation (NIDA, 2014; ONDCP, 2014; White, 2009).

Finally, based on resources located from U.S.-based national networks and recent short documents outlining the recovery school movement (Association of Recovery in Higher Education, 2016; Laudet et al., 2014; White & Finch, 2006), we anticipate that the majority of the programs will be located in the United States. We are aware of at least one potential recovery school program in China (Lin, Lu, & Wu, 2016, unpublished manuscript). However, we are not aware of other attempts to locate recovery school program literature on an international scale. An extensive systematic search would enable knowledge around whether, and if so, where such programs are in operation worldwide. Substance use disorders among youth are problematic in every nation, and many countries have instituted treatment and recovery resources specific to adolescents and young adults. Thus, this review could highlight gaps in recovery supports and potential solutions for addressing youth recovery moving forward.

INTERVENTION

The proposed review will include any recovery school program that is designed to support the academic success of students who are in recovery from substance use. Recovery schools are broadly defined as educational institutions, or programs at educational institutions, that are developed specifically for students in recovery and address recovery needs in addition to

academic development. Eligible recovery school programs can be at the secondary (Recovery High Schools [RHS]) or postsecondary level (College Recovery Communities [CRC]) and should meet the standards detailed by the Association of Recovery Schools (2013) or by the Association of Recovery in Higher Education (2015) as outlined below. Given the different models of recovery high schools and collegiate recovery communities, eligibility criteria differ by program model.

Recovery High Schools must meet the inclusion criteria described below to be eligible for inclusion in the review:

- i. Eligible recovery high school programs must have as their primary mission to provide education to youth in recovery from substance use or co-occurring disorders.
- ii. Eligible recovery high school programs must have an explicit goal of providing academic or educational instruction to high school students. The program must meet state requirements for awarding a secondary diploma. The program also must have direct contact with one or more students, and provide educational instruction via face-to-face, online, telephone, or video communication.
- iii. Eligible recovery high school programs must have an explicit goal of providing a high school environment oriented around recovery from substance use or co-occurring disorders and must require previous treatment and/or commitment to sobriety. Recovery school programs could include any of the following recovery support elements: individual, group, or parent counselling services; links to mutual aid support groups and/or requirement to attend additional continuing care support.
- iv. Eligible recovery high school programs must be available to any student in recovery from substance use or co-occurring disorders who meets state or district eligibility requirements for attendance.

Collegiate Recovery Communities must meet the inclusion criteria described below to be eligible for inclusion in the review:

- i. Eligible collegiate recovery communities must have an explicit goal of providing recovery support services and be focused on encouraging abstinence from use of substances.
- ii. Eligible collegiate recovery communities must be located in a postsecondary educational setting. The program must have direct contact with one or more students, and provide educational supports via face-to-face, online, telephone, or video communication.

- iii. Eligible collegiate recovery communities must have an explicit goal of providing a collegiate environment oriented around recovery from substance use. This goal could be met through any of the following or a combination of the following activities for youth in recovery: have a dedicated space for students in recovery to meet and support each other; offer group mutual aid meetings; offer individual counseling services with trained, specialized staff. They may also provide substance-free housing for recovering youth, organize sober events and community service activities, and educate the broader community in an effort to reduce stigma around addiction and generate a sober social culture.

Eligible comparison conditions must include traditional educational programs or services that do not explicitly have a recovery focus.

Exclusion criteria include:

- i. If the location of the educational program is in a substance use treatment center, then the program is not eligible for inclusion in this review. The rationale for this exclusion criterion is that educational programs delivered in formal treatment settings prioritize treatment services over academics and may involve more intensive treatment services, and thus do not qualify as a post-treatment or continuing care recovery support environment.

POPULATION

Eligible student populations will include students enrolled part-time or full-time in secondary (high school) or postsecondary (college or university) educational institutions. All ages of students are eligible for inclusion provided they are enrolled in an educational institution, but most secondary and postsecondary students are expected to be ages 15-25. Studies that include students who are not enrolled in educational institutions at the time of the intervention will not be eligible for inclusion.

Eligible student populations must be comprised of students who are in recovery from substance use. The definition for “in recovery” is broad, and encompasses any student with a history of using substances who is motivated or interested in reducing their substance use or maintaining abstinence from substance use. Due to inconsistent reporting in primary studies, students in recovery are not required to have a formal substance use disorder diagnosis (e.g., substance abuse or substance dependence diagnosis based on DSM criteria).

To be as inclusive as possible, no other eligibility restrictions will be placed on the eligible participant populations. Students in recovery who are enrolled in educational institutions in any country will be eligible for inclusion.

OUTCOMES

The primary outcomes eligible for this review are divided into two broad domains, with further subdivisions for constructs within each of these domains. Each construct within a larger outcome domain will be coded and analysed separately in the review.

Academic performance domain. The academic performance domain includes outcomes that assess students' academic achievement and performance in school. Eligible constructs within this domain include standardized achievement test scores (e.g., ACT, SAT, state assessments), grade-point average, high-school completion, college enrollment, and college completion.

Substance use domain. The substance use domain includes outcomes that assess students' consumption of alcohol and other substances of intoxication. Eligible constructs in this domain include alcohol, marijuana, cocaine, heroin, stimulant, and other substance use measures that collapse across different types of substances. Tobacco and caffeine use will not be eligible constructs in this domain, and will be excluded from the review.

STUDY DESIGNS

The proposed review will include studies that use an experimental or quasi-experimental design. For the primary analysis, eligible studies must compare outcomes for students enrolled in recovery school programs with students enrolled in one or more comparison condition that does not involve a recovery school program. To be eligible, study designs must meet at least one of the following criteria:

- i. **Randomized controlled trial:** Participants are randomly assigned to intervention and comparison conditions. Individual and cluster level randomization is acceptable.
- ii. **Quasi-randomized controlled trial:** Participants are assigned to intervention and comparison conditions via a quasi-random procedure, such as birth date or student record number.
- iii. **Quasi-experimental controlled trial with individual level matching:** Participants in the intervention and comparison conditions are allocated to conditions via a non-random process, but participants are individually matched on at least one measure of substance use and on student demographics (age, race/ethnicity, gender).
- iv. **Quasi-experimental controlled trial with pretest-adjusted outcomes:** Participants in the intervention and comparison condition are formed via a non-random process, but the study authors adjusted for pretest differences between groups (e.g., as pretest-adjusted posttest means, regression coefficients from models that adjust for pretest). For those

outcomes on which pretest data are not applicable (e.g., high-school graduation), adjustment must be done for a close proxy of a pretest.

- v. Quasi-experimental controlled trial with pretest data: Participants in the intervention and comparison condition are formed via a non-random process, but pretest data are available for each outcome. Pretest data must be reported in a form that permits assessment of the initial equivalence of the intervention and control groups on those variables via calculation of an effect size. For those outcomes on which pretest data are not applicable (e.g., high-school graduation), data for a close proxy of a pretest must be available.

OTHER ELIGIBILITY CRITERIA

Study Settings. Studies may be conducted in any setting and in any country.

Language of Publication. Studies may be published in any language.

Date of Publication. Studies must be reported in 1978 or later, given that the first collegiate recovery program was developed in 1977 (White & Finch, 2006) and the first recovery high school was developed in 1979 (Finch, 2015, personal communication; Ruben, June 22, 2000).

Form of Publication. To be as comprehensive as possible, studies may be reported in any form or type of publication, including but not limited to journal articles, books, book chapters, theses and dissertations, technical reports, conference papers, and other unpublished but disseminated formats.

GENERAL SYSTEMATIC REVIEW AND STATISTICAL PROCEDURES

The systematic review procedure will follow the Methodological Expectations of Campbell Collaboration Intervention Reviews (MEC2IR) conduct and reporting standards. The methodological procedures for the review and meta-analyses will be described fully in the review protocol. The risk of bias of included studies will be assessed using the Cochrane risk of bias tools for randomized and quasi-experimental studies. All meta-analyses will be conducted using random-effects inverse variance weights, using standard synthesis methods for estimating mean effect sizes and mixed-effect meta-regression models for examining moderator analyses. In the event that studies report multiple outcomes within the same construct category (e.g., two measures of academic achievement, two measures of alcohol use), we will use robust variance estimation to handle these statistical dependencies in the synthesis (Hedges, Tipton, & Johnson, 2010; Tanner-Smith & Tipton, 2014; Tipton, 2013). Publication bias and sensitivity analyses will be used to assess the robustness of the study findings.

REFERENCES

- Anderson, K. G., Ramo, D. E., Cummins, K. M., & Brown, S. A. (2010). Alcohol and drug involvement after adolescent treatment and functioning during emerging adulthood. *Drug and Alcohol Dependence*, *107*(2-3), 171-81. doi:10.1016/j.drugalcdep.2009.10.005
- Anderson, K. G., Ramo, D. E., Schulte, M. T., Cummins, K., & Brown, S. A. (2008). Impact of relapse predictors on psychosocial functioning of SUD youth one year after treatment. *Substance Abuse*, *29*(2), 97-106. doi:10.1080/08897070802093411
- American Psychiatric Association (APA). (2013). *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-V)*. Washington DC: American Psychiatric Association.
- American Society of Addiction Medicine (ASAM). (2013). *The ASAM Criteria. Treatment criteria addictive, substance-related, and co-occurring conditions*. Nevada: The Change Companies.
- Association of Recovery in Higher Education (ARHE). (2015). *Standards and recommendations*. Retrieved from <http://collegiaterecovery.org/standards-and-recomendations/>
- Association of Recovery in Higher Education (ARHE). (2016). *The collegiate recovery movement: A history*. Retrieved from <http://collegiaterecovery.org/the-collegiate-recovery-movement-a-history/>
- Association of Recovery Schools (ARS). (2013). *Standards for accreditation of recovery high schools*. Fort Washington, PA: The Association of Recovery High Schools. Retrieved from http://www.recoveryschools.org/sites/default/files/upload/ARS_Accreditation_Guide-12-04-13.pdf
- Australian Institute of Health and Welfare, Canberra. (2014). *Alcohol and other drug treatment services in Australia 2012-13*. Canberra ACT: Australian Institute of Health and Welfare. Drug Treatment Series No. 24. Retrieved from <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129548257>
- Brown, S. A., D'Amico, E. J., McCarthy, D. M., & Tapert, S. F. (2001). Four-year outcomes from adolescent alcohol and drug treatment. *Journal of Studies on Alcohol*, *62*(3), 381-8.
- Brown, S. A., & Tapert, S. F. (2004). Adolescence and the trajectory of alcohol use: Basic to clinical studies. *Annals New York Academy of Science*, *1021*, 234-44. doi:10.1196/annals.1308.028

Burleson, J. A., Kaminer, Y., & Burke, R. H. (2012). Twelve-month follow-up of aftercare for adolescents with alcohol use disorders. *Journal of Substance Abuse Treatment, 42*(1), 78-86. doi:10.1016/j.jsat.2011.07.001

Center for Behavioral Health Statistics and Quality. (2012). *Nearly half of college student treatment admissions were for primary alcohol abuse*. Data Spotlight (Treatment Episode Data Set).

Centers for Disease Control and Prevention. (2011). *Youth Risk Behavior Surveillance- United States, 2011*. MMWR 2012; 61(4): 24. Retrieved from: <http://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf>

Cleveland, H. H., Harris, K. S., Baker, A. K., Herbert, R., & Dean, L. R. (2007). Characteristics of a collegiate recovery community: Maintaining recovery in an abstinence-hostile environment. *Journal of Substance Abuse Treatment, 33*(1), 13-23. doi:10.1016/j.jsat.2006.11.005

Coleman, J. S. (1988). Social capital in the creation of human capital. *American Journal of Sociology, 94*, 95-120.

Council of Europe, Pompidou Group. (2006). *Young people and drugs. Care and treatment*. Retrieved from https://wcd.coe.int/ViewDoc.jsp?id=1214271#P1852_226970

Daddow, R., & Broome, S. (2010). *Whole person recovery: A user-centred systems approach to problem drug use*. London: RSA. Retrieved from Google Scholar: http://www.thersa.org/___data/assets/pdf_file/0011/362099/RSA-Whole-Person-Recovery-report.pdf

Derzon, J. H. (2007). Using correlational evidence to select youth for prevention programming. *Journal of Primary Prevention, 28*, 421-447.

El Ansari, W., Sebena, R., & Stock, C. (2013). Socio-demographic correlates of six indicators of alcohol consumption: survey findings of students across seven universities in England, Wales and Northern Ireland. *Archives of Public Health, 71*, 29.

European Monitoring Centre for Drugs and Drug Addiction. (2013). Table TDI-10. Primary drug and age. EU, Croatia, Norway and Turkey, 2011 or most recent year available. Data: statistical bulletin 2013. Retrieved from <http://www.emcdda.europa.eu/stats13#display:/stats13/tditab10>

Finch, A. J., & Frieden, G. (2014). The ecological and developmental role of recovery high schools. *Peabody Journal of Education, 89*(2), 271-287. doi:10.1080/0161956X.2014.897106

Finch, A., Karakos, H., & Hennessy, E. A. (2016). Exploring the policy context around Recovery High Schools: A case study of schools in Minnesota and Massachusetts. *Substance Abuse: Influences, Treatment Options and Health Effects* (In press).

Finch, A. J., Moberg, D. P., & Krupp, A. L. (2014). Continuing care in high schools: A descriptive study of recovery high school programs. *Journal of Child & Adolescent Substance Abuse*, 23(2), 116-129. doi:10.1080/1067828X.2012.751269

Fisher, E. A. (2014). Recovery supports for young people: What do existing supports reveal about the recovery environment? *Peabody Journal of Education*, 89(2): 258-270.

Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R. R., Passetti, L. L., & Petry, N. M. (2014). A randomized trial of assertive continuing care and contingency management for adolescents with substance use disorders. *Journal of Consulting and Clinical Psychology*, 82(1), 40-51. doi:10.1037/a0035264

Gonzales, R., Anglin, M. D., Beattie, R., Ong, C. A., & Glik, D. C. (2012). Understanding recovery barriers: Youth perceptions about substance use relapse. *American Journal of Health Behavior*, 36(5), 602-14. doi:10.5993/AJHB.36.5.3

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

Harris, K. S., Baker, A. K., Kimball, T. G., & Shumway, S. T. (2008). Achieving systems-based sustained recovery: A comprehensive model for collegiate recovery communities. *Journal of Groups in Addiction & Recovery*, 2(2-4), 220-237. doi:10.1080/15560350802080951

Harris, K. S., Kimball, T. G., Casiraghi, A. M., & Maison, S. J. (2014). Collegiate recovery programs. *Peabody Journal of Education*, 89(2), 229-243. doi:10.1080/0161956X.2014.897095

Hennessy, E. A., & Fisher, B. W. (2015). A meta-analysis exploring the relationship between 12-Step attendance and adolescent substance use relapse. *Journal of Groups in Addiction and Recovery*, 10, 79-96. <http://dx.doi.org/10.1080/1556035X.2015.999621>

Homel, J., Thompson, K., & Leadbeater, B. (2014). Trajectories of marijuana use in youth ages 15-25: Implications for postsecondary education experiences. *Journal of Studies on Alcohol and Drugs*, 75(4), 674-83.

Kaminer, Y., Burlison, J. A., Burke, R., & Litt, M. D. (2014). The efficacy of contingency management for adolescent cannabis use disorder: A controlled study. *Substance Abuse*, 35(4), 391-8. doi:10.1080/08897077.2014.933724

Karakos, H. L. (2014). Positive peer support or negative peer influence? The role of peers among adolescents in recovery high schools. *Peabody Journal of Education*, 89(2), 214-228. doi:10.1080/0161956X.2014.897094

Keane, M. (2011). *The role of education in developing recovery capital in recovery from substance addiction*. Dublin: Soilse Drug Rehabilitation Project. Retrieved from Google Scholar, Archived by WebCite® at <http://www.webcitation.org/6UZxzeZpo>

Kelly, J. F., & Myers, M. G. (2007). Adolescents' participation in alcoholics anonymous and narcotics anonymous: Review, implications and future directions. *Journal of Psychoactive Drugs*, 39(3), 259-69.

Kochanek, T. T. (2008). *Recovery high schools in Massachusetts: A promising, comprehensive model for adolescent substance abuse and dependence*. Retrieved from <http://massrecoveryhs.org/documents/RecoveryHighSchooloverview.pdf>

Kypri, K., Paschall, M. J., Langley, J., Baxter, J., Cashell-Smith, M., & Bourdeau, B. (2009). Drinking and alcohol-related harm among New Zealand university students: Findings from a national web-based survey. *Alcoholism: Clinical and Experimental Research*, 33, 307-314. doi:10.1111/j.1530-0277.2008.00834.x.

Larm, P., Hodgins, S., Larsson, A., Samuelson, Y. M., & Tengström, A. (2008). Long-term outcomes of adolescents treated for substance misuse. *Drug and Alcohol Dependence*, 96(1-2), 79-89. doi:10.1016/j.drugalcdep.2008.01.026

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

Lewis, T. F., & Mobley, A. K. (2010). Substance abuse and dependency risk: The role of peer perceptions, marijuana involvement, and attitudes toward substance use among college students. *Journal of Drug Education*, 40(3), 299-314.

Lin, J., Lu, Z., & Wu, W. (2016). Youth drug abuse treatment and recovery in Hong Kong: Christian Zheng Sheng College and the holistic interactive therapeutic community model. Unpublished manuscript, Vanderbilt University, Nashville, TN USA.

Lisdahl, K. M., Wright, N. E., Kirchner-Medina, C., Maple, K. E., & Shollenbarger, S. (2014). Considering cannabis: The effects of regular cannabis use on neurocognition in adolescents

and young adults. *Current Addiction Reports*, 1(2), 144-156. doi:10.1007/s40429-014-0019-6

Mason, M. J., Mennis, J., Linker, J., Bares, C., & Zaharakis, N. (2014). Peer attitudes effects on adolescent substance use: The moderating role of race and gender. *Prevention Science*, 15(1), 56-64. doi:10.1007/s11121-012-0353-7

Meier, A. (1999). *Social capital and school achievement among adolescents*. American Sociological Association Annual Meeting, Chicago, IL. Retrieved from <http://www.ssc.wisc.edu/cde/cdewp/99-18.pdf>

Menasco, M. A., & Blair, S. L. (2014). Adolescent substance use and marital status in adulthood. *Journal of Divorce & Remarriage*, 55(3), 216-238. doi:10.1080/10502556.2014.887382

Moberg, D. P., & Finch, A. J. (2007). Recovery high schools: A descriptive study of school programs and students. *Journal of Groups in Addiction & Recovery*, 2, 128-161. doi:10.1080/15560350802081314

Moberg, D. P., Finch, A. J., & Lindsley, S M. (2014). Recovery high schools: Students and responsive academic and therapeutic services. *Peabody Journal of Education*, 89(2), 165-182.

Moberg, D. P., Finch, A. J., Winters, K. C., & Lipsey, M. W. (2013, May). *Preventing academic failure and substance use relapse through recovery high schools*. Poster session presented at the meeting of the Society for Prevention Research, Washington, DC.

Monitoring the Future (MTF). (2013). Binge drinking: college students (percent). Available from http://www.healthindicators.gov/Indicators/Binge-drinking-college-students-percent_1436/Profile/ClassicData

National Institute on Drug Abuse (NIDA). (2014, January). Principles of adolescent substance use disorder treatment: A research-based guide. Retrieved from http://www.drugabuse.gov/sites/default/files/podata_1_17_14.pdf

Nelson, J. A., Henderson, S. E., & Lackey, S. (2015). Adolescent recovery from substance use in alternative peer groups: A revelatory case study. *Counseling Outcome and Research and Evaluation*, 6(2), 100-112. doi:10.1177/2150137815596044

Newcomb, M. D., & Bentler, P. M. (1988). Impact of adolescent drug use and social support on problems of young adults: A longitudinal study. *Journal of Abnormal Psychology*, 97(1), 64-75.

Office of National Drug Control Policy (ONDCP). (2014). *National drug control strategy*. Washington, D.C.: Office of National Drug Control Policy. Retrieved from http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/ndcs_2014.pdf

Patrick, M. E., Schulenberg, J. E., & O'Malley, P. M. (2013). High school substance use as a predictor of college attendance, completion, and dropout: A national multicohort longitudinal study. *Youth & Society*, epub. doi:10.1177/0044118X13508961

Perron, B. E., Grahovac, I. D., Uppal, J. S., Granillo, T. M., Shutter, J., & Porter, C. A. (2011). Supporting students in recovery on college campuses: Opportunities for student affairs professionals. *Journal of Student Affairs Research and Practice*, 48(1), 47-64. doi:10.2202/1949-6605.6226

Pugatch, M., Knight, J. R., McGuinness, P., Sherritt, L., & Levy, S. (2014). A group therapy program for opioid-dependent adolescents and their parents. *Substance Abuse*, 35(4), 435-41. doi:10.1080/08897077.2014.958208

Ramo, D. E., Prince, M. A., Roesch, S. C., & Brown, S. A. (2012). Variation in substance use relapse episodes among adolescents: A longitudinal investigation. *Journal of Substance Abuse Treatment*, 43(1), 44-52. doi:10.1016/j.jsat.2011.10.003

Ruben, B. (2000, Jun 22). Sharing the lessons of sobriety. *The Washington Post*, pp. M.01-MDM.1. Retrieved from <http://search.proquest.com/docview/408647808?accountid=14816>.

Smock, S. A., Baker, A. K., Harris, K. S., & D'Sauza, C. (2011). The role of social support in collegiate recovery communities: A review of the literature. *Alcoholism Treatment Quarterly*, 29(1), 35-44. doi:10.1080/07347324.2010.51107

Spear, S.F., & Skala, S. Y. (1995). Posttreatment services of chemically dependent adolescents. In E. Rahdert & D. Czechowicz (Eds.), *Adolescent drug abuse: Clinical assessment and therapeutic interventions* (NIDA Research Monograph 156) (pp. 341-364). Rockville, MD: U.S. Department of Health and Human Services, National Institute on Drug Abuse.

Squeglia, L. M., Jacobus, J., & Tapert, S. F. (2009). The influence of substance use on adolescent brain development. *Clinical EEG and Neuroscience*, 40(1), 31-8.

Stanger, C., Ryan, S. R., Scherer, E. A., Norton, G. E., & Budney, A. J. (2015). Clinic- and home-based contingency management plus parent training for adolescent cannabis use disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*, 54(6), 445-453.e2. doi:10.1016/j.jaac.2015.02.009

Substance Abuse and Mental Health Services Administration (SAMHSA). 2013 National Survey on Drug Use and Health (NSDUH). Table 6.89B—Binge Alcohol Use in the Past

Month among Persons Aged 18 to 22, by College Enrollment Status and Demographic Characteristics: Percentages, 2012 and 2013. Retrieved from <http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect6peTabs55to107-2013.htm#tab6.89b>

Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2016). *Alcohol and/or illicit drug treatment receipt (percent)*, NSDUH. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from http://www.healthindicators.gov/Indicators/Alcohol-and-or-illicit-drug-treatment-receipt-percent_1455/Profile/Chart_Bar_Demographics

Sussman, S. (2010). A review of Alcoholics Anonymous/ Narcotics Anonymous programs for teens. *Evaluation & the Health Professions*, 33(1), 26-55. doi:10.1177/0163278709356186.

Svensson, R. (2000). Risk factors for different dimensions of adolescent drug use. *Journal of Child and Adolescent Substance Abuse*, 9(3), 67-90.

Tanner-Smith, E. E., Finch, A. J., Moberg, D. P., & Karakos, H. (2014). Recovery high schools: Innovative schools supporting recovery from substance abuse. *American Educational Research Association*, Philadelphia, PA.

Tanner-Smith, E. E., Wilson, S. J., & Lipsey, M. W. (2013). The comparative effectiveness of outpatient treatment for adolescent substance abuse: A meta-analysis. *Journal of Substance Abuse Treatment*, 44, 145-158. doi:10.1016/j.jsat.2012.05.006.

Terrion, J. L. (2012). The experience of post-secondary education for students in recovery from addiction to drugs or alcohol: Relationships and recovery capital. *Journal of Social and Personal Relationships*, 30, 1-21. doi:10.1177/0265407512448276

Terrion, J. (2014). Building recovery capital in recovering substance abusers through a service-learning partnership: A qualitative evaluation of a communication skills training program. *Journal of Service-Learning in Higher Education*, 3, 47-63.

Thoma, R. J., Monnig, M. A., Lysne, P. A., Ruhl, D. A., Pommy, J. A., Bogenschutz, M., . . . Yeo, R. A. (2011). Adolescent substance abuse: The effects of alcohol and marijuana on neuropsychological performance. *Alcoholism: Clinical and Experimental Research*, 35(1), 39-46. doi:10.1111/j.1530-0277.2010.01320.x

Waldron, H. B., & Turner, C. W. (2008). Evidence-based psychosocial treatments for adolescent substance abuse. *Journal of Clinical Child and Adolescent Psychology*, 37, 238-261.

Wambeam, R. A., Canen, E. L., Linkenbach, J., & Otto, J. (2013). Youth misperceptions of peer substance use norms: A hidden risk factor in state and community prevention. *Prevention Science*, 15(1), 75-84. doi:10.1007/s11121-013-0384-8

White, W. L. (2009). The mobilization of community resources to support long-term addiction recovery. *Journal of Substance Abuse Treatment*, 36(2), 146-58. doi:10.1016/j.jsat.2008.10.006

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

White, W.L., Evans, A. C., Ali, S. Abrahams, I. & King, J. (2009). *The recovery revolution: Will it include children and adolescents?* Philadelphia, PA: Department of Behavioral Health and Mental Retardation Services.

White, W. L., & Finch, A. J. (2006). The recovery school movement: Its history and future. *Counselor*, 7(2), 54-57. Retrieved from www.bhrm.org

White, A. M., Jordan, J. D., Schroeder, K. M., Acheson, S. K., Georgi, B. D., Sauls, G., . . . Swartzwelder, H. S. (2004). Predictors of relapse during treatment and treatment completion among marijuana-dependent adolescents in an intensive outpatient substance abuse program. *Substance Abuse*, 25(1), 53-9. doi:10.1300/J465v25n01_08

White, W. L., Kelly, J. F., & Roth, J. D. (2012). New addiction-recovery support institutions: Mobilizing support beyond professional addiction treatment and recovery mutual aid. *Journal of Groups in Addiction & Recovery*, 7(2-4), 297-317. doi:10.1080/1556035X.2012.705719

Winters, K. C., Stinchfield, R., Latimer, W. W., & Lee, S. (2007). Long-term outcome of substance-dependent youth following 12-step treatment. *Journal of Substance Abuse Treatment*, 33(1), 61-9. doi:10.1016/j.jsat.2006.12.003

REVIEW AUTHORS

Lead review author: The lead author is the person who develops and co-ordinates the review team, discusses and assigns roles for individual members of the review team, liaises with the editorial base and takes responsibility for the on-going updates of the review.

Name:	Emily A. Hennessy
Title:	Doctoral Candidate
Affiliation:	Peabody Research Institute, Human and Organizational Development
Address:	Vanderbilt University, Peabody College 230 Appleton Place, PMB #90
City, State, Province or County:	Nashville, TN
Postal Code:	37203
Country:	USA
Phone:	978-810-0398
Email:	Emily.a.hennessy@vanderbilt.edu

Co-author(s): (There should be at least one co-author)

Name:	Emily E. Tanner-Smith
Title:	Research Assistant Professor
Affiliation:	Peabody Research Institute, Human and Organizational Development
Address:	Box 0181 GPC, 230 Appleton Place
City, State, Province or County:	Nashville, TN
Postal Code:	37203
Country:	USA
Phone:	615-322-6304
Email:	E.tanner-smith@vanderbilt.edu

Name:	Andrew J. Finch
Title:	Associate Professor of the Practice
Affiliation:	Vanderbilt University, Human and Organizational Development
Address:	Box 90 GPC, 230 Appleton Place
City, State, Province or County:	Nashville, TN

Postal Code:	37203
Country:	USA
Phone:	615-322-8684
Email:	Andrew.j.finch@vanderbilt.edu

Name:	Nila A. Sathe
Title:	Assistant Director
Affiliation:	Vanderbilt University Evidence-based Practice Center
Address:	2525 West End Ave #600
City, State, Province or County:	Nashville, TN
Postal Code:	37203
Country:	USA
Phone:	615-936-8299
Email:	Nila.sathe@vanderbilt.edu

Name:	Shannon A. Potter
Title:	Program Manager
Affiliation:	Vanderbilt University Evidence-based Practice Center
Address:	2525 West End Ave #600
City, State, Province or County:	Nashville, TN
Postal Code:	37203
Country:	USA
Phone:	615-343-3067
Email:	Shannon.potter@vanderbilt.edu

ROLES AND RESPONSIBILITIES

- Content: Finch, Hennessy, Tanner-Smith
- Systematic review methods: Hennessy, Potter, Sathe, Tanner-Smith
- Statistical analysis: Hennessy, Tanner-Smith
- Information retrieval: Hennessy, Potter, Sathe

FUNDING

This review will be partially supported with a grant from the Campbell Collaboration.

POTENTIAL CONFLICTS OF INTEREST

Three of the authors of this review (AJF, EAH, ETS) are involved in one ongoing primary study examining the effects of recovery high schools. If that study is deemed eligible for inclusion in the review, external and independent data collectors will be used to extract all data from that study. This will be reported transparently in the protocol and completed review.

The authors of this review have no other conflicts of interest to declare.

PRELIMINARY TIMEFRAME

- Submission date for draft protocol: July 31, 2016
- Submission date for draft review: March 31, 2017

AUTHOR DECLARATION

Authors' responsibilities

By completing this form, you accept responsibility for preparing, maintaining, and updating the review in accordance with Campbell Collaboration policy. The Coordinating Group will provide as much support as possible to assist with the preparation of the review.

A draft protocol must be submitted to the Coordinating Group within one year of title acceptance. If drafts are not submitted before the agreed deadlines, or if we are unable to contact you for an extended period, the Coordinating Group has the right to de-register the title or transfer the title to alternative authors. The Coordinating Group also has the right to de-register or transfer the title if it does not meet the standards of the Coordinating Group and/or the Campbell Collaboration.

You accept responsibility for maintaining the review in light of new evidence, comments and criticisms, and other developments, and updating the review every five years, when substantial new evidence becomes available, or, if requested, transferring responsibility for maintaining the review to others as agreed with the Coordinating Group.

Publication in the Campbell Library

The support of the Coordinating Group in preparing your review is conditional upon your agreement to publish the protocol, finished review, and subsequent updates in the Campbell Library. The Campbell Collaboration places no restrictions on publication of the findings of a Campbell systematic review in a more abbreviated form as a journal article either before or after the publication of the monograph version in *Campbell Systematic Reviews*. Some journals, however, have restrictions that preclude publication of findings that have been, or will be, reported elsewhere and authors considering publication in such a journal should be aware of possible conflict with publication of the monograph version in *Campbell Systematic Reviews*. Publication in a journal after publication or in press status in *Campbell Systematic Reviews* should acknowledge the Campbell version and include a citation to it. Note that systematic reviews published in *Campbell Systematic Reviews* and co-registered with the Cochrane Collaboration may have additional requirements or restrictions for co-publication. Review authors accept responsibility for meeting any co-publication requirements.

I understand the commitment required to undertake a Campbell review, and agree to publish in the Campbell Library. Signed on behalf of the authors:

Form completed by:



Date:

6/27/2016