Exploring Assessment Measures to Enhance the Practical Understanding and Application of Recovery Capital for Addiction Service Providers

by

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Introduction

In Canada, 19.3% of deaths are attributed to alcohol, illegal drugs, and tobacco each year (Rehm et al., 2006). Annually, substance use disorders (SUD) costs $1,267 per capita, amounting to a significant burden on the Canadian healthcare system (Rehm et al., 2006). With the opioid crisis spreading across the country, SUD has been at the forefront of conversation in headlines and healthcare systems (Government of Canada, 2017). SUD does not discriminate between various ages, ethnicities, socioeconomic status, religions, or genders, as millions of Canadians from coast to coast have been affected by this epidemic (Pearson, Janz & Ali, 2013). SUD impacts not only the individual, but also the individual’s family, friends, co-workers, workplace, and community (Lander, Howsare & Bryne, 2013; Frone & Brown, 2010). The cost of SUD, therefore, is much more widespread than simply economic, with considerable social, emotional, and psychological costs as well (Lander, Howsare & Bryne, 2013).

Although the SUD epidemic is daunting, recovery is possible. Half or more of individuals ultimately recover from SUD, although several rounds of treatment may be needed, as recovery is not a linear process (Dennis, Scott, Funk, & Foss, 2005; White, 2012; Dennis, Foss, & Scott, 2007). Pathways to recovery are also unique, with varying treatment modalities working for some but not for others (Neale et al., 2015).

The vast amount of current literature on addiction and recovery has been presented through an etiological perspective, largely concerned with those factors thought to be causal to the onset of addiction. Although necessary, the unintended consequence of this research focus has resulted in a limited understanding as to how individuals initiate and maintain recovery. Over the past few years, there has been an increasing shift towards a more recovery-oriented, prospective approach in better understanding the recovery process. This important work has focused on the lived experiences of those recovering to inform professionals, communities, workplaces, families and other groups impacted, as to the factors and forces which support one’s transformation from addiction to recovery.
Recovery

One of the major drawbacks to the development of recovery research is a lacking consensus on a generally understood definition, as numerous definitions of recovery have been put forward with limited consensus across the SUD field (Betty Ford Institute Consensus Panel, 2007; Kaskutas et al., 2014; Laudet & White, 2008; UK Drug Policy Commission, 2008). Despite the lack of alignment, there are many definitions of recovery sharing similar characteristics: recovery is sustainable, holistic, voluntary, continuous, a journey towards well-being, and a constant practice throughout life (Betty Ford Institute Consensus Panel, 2007; White, 2007; Faces and Voices of Recovery, 2013). Furthermore, definitions of recovery include striving towards abstinence (complete cessation of substance use), quality of life (physical, mental, and social health), and positive citizenry (consideration and respect for others around them) (Betty Ford Institute Consensus Panel, 2007; White, 2007; Faces and Voices of Recovery, 2013).

Recovery Capital

In recent years a solution-focused, recovery-oriented approach to addiction care has been gaining prominence with service providers, policy makers and other stakeholders (White & Cloud, 2008). The emerging concept of recovery capital has largely supported this progressive momentum. Granfield and Cloud (1999) established the concept of recovery capital, first conceptualized as a method of inquiry sought to quantify an individual’s assets in relation to their recovery potential. According to their definition, recovery capital includes the breadth and depth of resources, both internal and external, which can be drawn upon to initiate and sustain recovery (Granfield & Cloud, 1999). This definition accords well with the definition of “recovery” which for the purposes of this research is defined by the American Society of Addiction Medicine as “a process of sustained action that addresses the biological, psychological, social, and spiritual disturbances related to addiction” (American Society of Addiction Medicine, 2013, p. 2). White and Cloud (2008) classified three distinct categories, vaguely reminiscent of a micro, meso, and macro level of analysis, which they labeled “personal recovery capital”, “family/social recovery capital”, and “community recovery capital” (p. 2).
At a fundamental level, the emerging framework of recovery capital can be thought of as an extension of social capital, originally theorized by Pierre Bourdieu. Bourdieu (1985) defined social capital as “the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition” (p. 248). Bourdieu’s concept of social capital can be separated into two primary categories: (1) the social connections themselves, which widen the resources available to the individual through these connections, and (2) the amount and quality of those resources (Portes, 1998). While Bourdieu and many others thereafter employed the theoretical lens of social capital more broadly to the general population, the underlying premises uniquely interface with the multifactorial process of one’s journey to recover from an addiction.

In addiction service delivery, the recovery capital framework can be used to develop treatment plans, evaluate progress as one moves through their recovery journey, and has the potential to inform a practical feedback loop that can be used at an individual level to guide one's own recovery process. The utility of this assessment would be enhanced by further research on how useful the assessment is in creating person-centered, comprehensive, culturally responsive care plans. One exacting challenge, described by White and Cloud (2008) is one of human nature, where complex personal qualities and conditions may not fall neatly into a category, a challenge that is not addressed in the current literature.

**Research Procedure and Findings**

This present study has been established as a two-part, mixed methods research agenda. The research hypothesis proposed is that the acquisition of recovery capital over time significantly predicts one’s ability to remain abstinent from psychoactive substances. All individuals admitted to the study were offered participation via a nonprobability random sample of individuals admitting to residential SUD treatment at Cedars at Cobble Hill in British Columbia, Canada.

A total of 114 participants were engaged in the research. Inclusion criteria for this study included: 1) patients over the age of 18, and 2) individuals meeting the criteria for SUD as outlined in the DSM-V.
The study utilized the Assessment of Recovery Capital (ARC), a psychometrically validated assessment tool developed in 2012 (Groshkova et al.) supplemented by a proprietary survey at 3 intervals analyzed in combination with a myriad of individual level sociodemographic data facilitating various tests in search of statistically significant relationships. The ARC includes 50 items assessing the individual’s internal and external resources, subdivided into 10 subscales: substance use and sobriety, global psychological health, global physical health, citizenship, social support, meaningful activities, housing and safety, risk-taking, coping and life functioning, and recovery experience (Groshkova et al., 2012). The ARC has previously been validated with sufficient reliability (0.50 - 0.73) for overall scale and subscales, and concurrent validity compared to the WHOQOL scale and Treatment Outcome Profile (Groshkova et al., 2012). Groskova et al. (2012) also suggested that the ARC has shown to be more useful and practical than the Opiate Treatment Index or the Maudsley Addiction profile because of its focus on “meaningful gains rather than the management and reduction of harms” (p. 192) (Darke, Hall, Wodaki, Heather & Ward, 1992; Marsden et al., 1998). Survey responses were analyzed using thematic analysis focusing on the individuals’ lived experiences through their recovery initiation and early recovery process in hopes of augmenting the quantitative results and, more ambitiously, the overall recovery capital framework.

**Key Findings**

Concerning the influence of recovery capital on the abstinence status of individuals, it was systematically revealed that personal, social, and community resources promote the effort of individuals to retain their abstinent status. Specifically, commitment to sobriety, positive life functioning, and psychological health were the most influential protective factors for abstinence. Satisfactory recovery experience, participation in meaningful and community activities, as well as social support, made a significant contribution to the prevention of relapse episodes. It was observed that the acquisition of recovery capital at three months post-treatment significantly increased the probability of remaining abstinent from alcohol and other drugs at three months post-treatment. The odds ratio suggested that for each increase of one point in recovery capital, an individual is 1.16 times more likely to be classified as abstinent from alcohol and other drugs at three months post treatment.
Noteworthy, those resources were most valuable at a later stage of recovery (three months post-treatment), suggesting that recovery capital both takes time to develop, and active measures to maintain. Therefore, service delivery professionals should provide individuals in recovery with the necessary skills and tools to enhance their coping mechanisms, alter their surroundings and engage in meaningful activities, and obtain a supportive social network. On that note, the emphasis should be on the cultivation of resources that have the potential to accompany individuals throughout their recovery process beyond acute program facilities.

Furthermore, it was observed that certain sociodemographic groups require additional support to acquire sufficient levels of recovery capital. To elaborate, men displayed greater psychological resilience, better coping skills and life functioning, and an overall better recovery experience than women. In addition, drug users had a greater difficulty to acquire recovery capital throughout treatment progression than alcohol users, especially in their participation in community and meaningful activities, their physical health, as well as in their ability to obtain financial independence and refrain from risk taking behaviours. Consequently, it is advised that SUD treatment professionals perform in-depth discussions with those vulnerable groups to understand their distinct difficulties and facilitate their post-treatment transition.

Interestingly, individuals diagnosed with SUD suffered from mild depression and most of them had a history of family addiction (89%), which supports the plethora of research evidence denoting depression and family addiction as severe risk factors. Considering these patterns, it is recommended that SUD treatment professionals receive adequate and up-to-date psychotherapy training to treat patients with depressive symptoms and help them create and sustain a post-treatment housing and social network environment free of drugs.

The findings from the qualitative analysis showed that the most significant category in recovery management post-treatment was personal human capital (37.76%), followed by social capital (25.29%), community support (21.23%), and lastly physical capital (14.88%). Personal and social capital appear to be the most significant in recovery capital development, which supports some of the existing literature that describes self-efficacy and social supports as key factors in recovery capital. Personal capital emphasized psychological, spiritual, and emotional aspects of the self, which appear to be primary factors in recovery capital in this study.
Human capital described in the analysis largely includes healthy, positive emotions and attitudes about oneself, increased self-awareness, improved emotional-stability, increased self-efficacy, optimistic outlook on life, enhanced spiritual connection and practices, increased education about addiction and knowledge of coping tools, and having the personal will to live.

This aligns with the existing literature regarding the facet of self-efficacy, or perceived confidence as a supportive factor in sustained recovery. Aside from psychological abilities, spirituality was a top reported factor in supporting one’s recovery transition. The findings suggest that through a personal spiritual connection and practices such as meditation, prayer, affirmations, and faith, individuals can gain and strengthen valuable inner resources, such as resilience, emotional-stability, self-acceptance, self-worth, self-awareness, self-efficacy, positive outlook on life, and increased decision-making capabilities to cope with recovery and life in general.

Social capital in this analysis describes the social support network one has, not only regarding friends, spouses, or family, but also in the connections formed with others during treatment or in recovery houses, which were emphasized as significant supporting factors in a positive recovery transition. This point is significant because it supports the idea that the addiction care system in Canada ought to employ a gradual step process of recovery, whereby individuals may benefit and develop recovery capital by transitioning more gradually from high to lower levels of care. Improved relationships and social involvement post treatment were also discussed as factors of recovery capital during transition, as well as improved communication and ability of expression. It is possible that social isolation may be linked with addictive behaviours, thus the importance of support from social environments, particularly support groups from individuals with similar experiences, during treatment and post-treatment should not be overlooked.

Regarding community capital, the analysis showed that individuals receiving support from other people who have had similar experiences had a very positive impact on their recovery. Living in a recovery house with others appeared to be a very helpful and significant factor in sustaining recovery. This contributes to the evidence that patients may have a higher chance of sustained recovery if they live in recovery houses with others after treatment.
Physical capital is described as improved health and increased healthy behaviours, the joys of sobriety, and opportunities for jobs, education, volunteering, and travel. Participants described how these factors were both new outcomes they experienced post-treatment and factors they most looked forward to continuing after treatment, which suggests that planning for life post-treatment may be a factor in supporting sustained recovery. In addition to sobriety and abstinence, engagement in activities with sober friends or people who have had similar experiences may be another factor of recovery capital.

Some similarities were observed within the findings from this paper and from paper one, regarding the recovery capital factors which contributed to or supported sustained recovery. As discussed in paper one, individuals who remained abstinent had a more positive recovery experience, which included factors such as having a sense of life purpose. This supports the finding from the qualitative analysis, whereby individuals described a shift in their outlook on life towards post-treatment, which was expressed as the will to live a healthy life with an increased feeling of having a life purpose, as compared to during the height of addiction. While these findings conceptually indicate an alignment with the commonly agreed upon characteristics of recovery such as enhanced quality of life, personal life meaning and purpose and prosocial behaviours, further research is required to better understand the positively contributing factors within each of these elements which support an individual’s ability to remain abstinent from alcohol and other drugs. As such, the current findings do not present a simple cause and effect relationship although they do indicate a promising area for future work.

Similarly, social support was outlined in paper one as a factor that positively impacted individual’s abstinence status, while in this paper, social capital was the second most frequently reported factor in supporting sustained recovery. Lastly, both papers discovered how community engagement such as mutual support groups and connecting with others who have similar experiences with addiction is a positive factor in recovery transition and sustained abstinence. It should be noted that the qualitative data analysis did not distinguish between participants who remained abstinent or who did not remain abstinent from alcohol and other drugs post-treatment, although general similarities can still be observed.
Discussion

Pathways to recovery from SUD are not linear. It could be argued that each pathway is unique and requires a multifaceted approach (Neale et al., 2015). The same principle should be applied to future research directions for optimal recovery outcomes to be achieved. SUD is a disorder with serious psychological and physical consequences that could even prove to be fatal for the individual diagnosed with SUD. Therefore, it is crucial that the principles of treatment programs are based on empirical evidence from rigorous research designs that allow for causal inferences to be made. Considering the long-term course of SUD recovery, it is advised that longitudinal studies are conducted, and structural equation modelling analyses are performed, so that the experience of patients is captured at each stage of recovery and conclusions are drawn with extra layers of confidence.

Furthermore, SUD does not discriminate among sociodemographic groups, including gender, ethnicity, age, socioeconomic status, or religion. Different sociodemographic groups do experience SUD and SUD recovery distinctively, as they are presented with different opportunities and challenges. However, research on behavioural sciences typically collects samples from Western, Educated, Industrialized, Rich, and Democratic (WEIRD) societies, which leads to the underrepresentation of certain sociodemographic groups and observations of limited generalizability (Henrich, Heine, & Norenzayan, 2010). Consequently, scholars/clinical researchers should aim for diverse samples to enable SUD treatment professionals to apply recovery strategies that are efficient for a broad range of sociodemographic groups.

Moreover, further research on the concept of recovery capital is recommended to identify those assets and barriers that exert a considerable influence on individuals’ recovery process. Indicatively, a recent systematic literature review of 35 studies on recovery capital research revealed that the conceptualization and utilization of recovery capital is inconsistent and the quantification of recovery capital through a psychometrically sound scale was proposed (Oser et al., 2016). Specifically, it was stated that the initial conceptualization of recovery capital was based on Caucasian, male adults in natural recovery and, thus, the perspective of other individuals or groups on what constitutes a meaningful and sustainable recovery has been neglected. In addition, only three instruments measuring recovery capital are available thus far.
and no consensus exists on which scale should be used under which context. Out of three instruments, the ARC scale (Groshkova et al., 2013) displays the best psychometric properties, but according to the literature review it has been only used in six studies. Interestingly, other studies did not employ any of the pre-existing recovery capital scales instead, they measured or modelled recovery capital with an individual set of variables (see Oser et al., 2016, p. 7).

Finally, the application of a strengths-based psychology lens and tools for addiction and recovery research could lead to an innovative movement in prevention and intervention. In further detail, Krentzman (2013) conducted a relevant systematic review and observed that the cultivation of positive psychological feelings has the potential to support the recovery journey of individuals. For instance, a study by McCoy (2009) showed that hope, a central construct in positive psychology, enhanced protective factors for relapse (i.e. purpose in life, social support, & self-efficacy) and inhibited risk factors for relapse (i.e. psychiatric symptoms). Akhtar and Boniwell (2010) also piloted a positive psychology intervention that involved 10 UK adolescents in SUD treatment and observed significant increases in happiness, optimism, and positive affect; thus, psychological outcomes are valuable for sustainable recovery from alcohol and other drugs.

Conclusion

The mixed methods approach employed within this research is intended as a first step to begin elucidating key aspects of one's personal journey and to advance the overall quantification to assess one’s recovery capital. With increased understanding in specific domains, service providers and individuals could engage the assessment with intention to further their goal of a long term, sustainable recovery.

Although not a problem exclusive to the field of addiction, mobilizing novel approaches from research to practice, commonly referred to as the ‘transfer of knowledge’, remains a considerable challenge (Buchanan, 2013). Knowledge mobilization (KM), as defined by Bannister and Hardill (2012), is “getting the best evidence to the appropriate decision makers in both an accessible format and in a timely fashion so as to influence decision making” (p. 172). KM is an interactive process between the researchers who create knowledge and those who use it
(Sudsawad, 2007). Meanwhile, knowledge translation (KT) is defined as, “the collaborative and systematic review, assessment, identification, aggregation and practical application of high-quality disability and rehabilitation research by key stakeholders (i.e., consumers, researchers, practitioners, policy makers) for the purpose of improving the lives of individuals with disabilities” (NCDDR, 2007).

Perhaps somewhat unique to the addictions field is the increasingly polarizing, at times even adversarial, gap between large cohorts of stakeholders possessing dramatically different philosophical approaches to addressing this societal challenge. Despite this current reality, there are aligning themes that have the capacity to break down increasingly steadfast barriers across various stakeholders. Whether in favour of harm reduction approaches, abstinence-based interventions or every approach on the spectrum, the advantage provided by recovery capital lies within its relatively agnostic view on the definition of recovery. While the present study does adopt a definition of recovery, future work in this area can be agile to various understandings of a successful outcome for an individual. In that, the actual drug one consumes is merely one component of the addictive process whereas the individual, community and family destruction are created far more by the behaviours and environment created by prolonged addiction. Similarly, abstaining from illicit substances as a function of recovery has far less to do with the drug itself; rather, abstinence focuses on the quality of life within the individual’s psychosocial environment as he or she proceeds through recovery. To that end, future work in this area can and should be conducted across the spectrum of service delivery in the addiction field and be agile to how any one individual or group defines the state of recovery itself.

In terms of becoming a predictable and repeatable model for positive, sustained long-term recovery, recovery capital is in its infancy. The framework must work towards a more specific understanding of one's overall assets that can be built upon and further developed to support the quality of life needed for sustainable long-term recovery. It should also work towards an enhanced appreciation for the nuances and uniqueness of individuals in moving towards person-centered recovery goals. The hope is that this research is another step towards that goal and, ultimately, the vision of comprehensively assessing and supporting those in need.
References


