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The assessment of recovery capital: properties and psychometrics of a measure of addiction recovery strengths.

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Drug and Alcohol Review: 2013, 32(2), p. 187–194.

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Testing in the UK suggested that a questionnaire assessing the 'recovery capital' resources which help overcome addiction might underpin more recovery-oriented assessments of services and of client progress and needs – but only a study which followed up patients could confirm this, and do some of the questions assess ability to recover, or recovery itself?

SUMMARY English and the Scottish national strategies on drug problems reflect calls to shift addiction treatment from models of acute and palliative care to models of assertive and sustained recovery management. Operationalising 'recovery' as a principle which can guide the transformation of health care systems hinges on the ability to define that concept and to measure the related concept of 'recovery capital'.

Key points

'Recovery capital' is the sum of the resources an individual can draw on to initiate and sustain recovery from substance use problems, a concept not well measured by usual problem-based assessments of treatment outcomes.

The featured study developed a questionnaire to measure recovery capital and tested its reliability and validity on people in addiction treatment and recovery in Britain.

It was found to be a stable measure substantially related to other similar measures and to duration of recovery, suggesting it might aid recovery-oriented assessment of treatment services and of an individual's progress and needs.

However, it will be important to test whether the measure can predict later recovery, and rather than assessing an underlying ability to recover, it seems partly to measure recovery itself.

For the UK, recovery has been defined as a process of "voluntarily sustained control over substance use which maximises health and well-being and participation in the rights, roles and responsibilities of society". Similarly, a US expert group defined it as "a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship". Recovery capital has been defined as "the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from [alcohol and other drug] problems". This strengths-based concept is not captured well by traditional problem-based assessments of the outcomes of substance use treatment. New measurement tools are needed that focus on the personal and social assets that sustain long-term recovery and improved quality of life.

The featured study developed one such tool, a questionnaire designed to measure recovery capital by capturing indices of the positive personal and social resources which help an individual meet their needs and aspirations in their recovery journey.

Academic literature and discussions with practitioners, service users and people in various stages of recovery generated an initial set of 50 questionnaire items – five assessing each of 10 dimensions of recovery capital mainly based on how respondents feel or assess their situation at that time. Respondents who ticked all five items in each dimension would score a maximum 50 on this 'Assessment of Recovery Capital' (ARC) scale. The scale was then piloted on the clients of a community substance use rehabilitation service in Edinburgh, Scotland, before being tested on both a sample of 142 clients in treatment in Scotland, and 176 people in recovery from their substance use problems recruited from recovery groups and communities across England. In both cases there was a fairly even representation of primary alcohol and drug problems.

A measure cannot be relied on if for no apparent reason the same people score very differently a few days later. To test the stability of the recovery capital measure, a randomly selected 45 clients in the treatment sample filled in the questionnaire again a week later; each individual's scores could be matched to their previous scores. It was also important to show that the questionnaire assessed what it was supposed to assess. To test how far each individual's scores corresponded to their scores on other similar but already well established assessments, a random subsample of 72 treatment participants completed the World Health Organization's (WHO) brief quality of life assessment. Additionally, the recovery sample completed the physical, psychological and quality of life items from the Treatment Outcome Profile (TOP) used to assess treatment progress in the UK.

Main findings

Retest scores were sufficiently close to the previous week's scores to indicate that the measure's reliability was satisfactory.

An individual's total score and scores on all 10 recovery capital subscales were substantially and significantly related to how they scored on the psychological, physical and environmental dimensions of WHO's quality of life questionnaire. Relationships to the social dimension were less close but still

generally statistically significant; an exception was the citizenship and community involvement subscale, which was only weakly related to social quality of life as measured by WHO.

Total recovery capital scores were significantly related to scores on TOP's quality of life question. Though statistically significant and in the expected direction, compared to WHO's questionnaire, scores on the recovery capital measure's physical and psychological health subscales were less closely related to scores on the corresponding TOP items.

Among the recovery sample, scores on the recovery capital scale's physical health subscale distinguished well between people who (according to their own assessments) were versus were not engaged in work or other meaningful activity. Similarly, scores on the housing and safety subscale distinguished between people who said they were versus were not stably housed.

Individuals who scored highly on one recovery capital subscale tended to score highly on others, to the degree that their total score could be interpreted as reflecting their position on a single underlying recovery capital dimension. If this was the case, it would be expected that the total score would predict well whether people were in stable recovery, conventionally defined as at least five years in duration. This was what was found; a cut off score of 27.5 out of 50 was optimal and was highly predictive of recovery stage.

The authors' conclusions

Focusing on the growth of positive strengths rather than the management and reduction of harms, for non-acute treatment settings such as rehabilitation and aftercare, the ARC measure of recovery capital is likely to provide a more useful indicator of effectiveness than pathology-focused assessments. It takes around five to ten minutes to complete and was acceptable to participants in a range of treatment and non-treatment settings. Among substance users, the scale seems both a consistent and valid indicator of recovery strengths and resources and of the duration of recovery, and can be interpreted as reflecting the single underlying dimension of recovery capital. As well as assessing services, ARC can be used to help assess where clients are in their recovery journeys and what their growth needs are likely to be as they progress.

COMMENTARY Even if the term itself is not used, the bolstering of recovery capital – often in very short supply among multiply damaged and disadvantaged treatment caseloads – is being seen in the UK and in the USA as a key task for recovery-oriented treatment systems. Lacking these resources, dependent users may be able to become drug free, but will be unlikely to sustain their recovery.

Like the featured study, another study involving the same authors has related their recovery capital measure to other similar variables, this time among recovery group members identified through English addiction treatment services. By design all were in recovery for at least six months. Once other factors had been taken in to account, the duration of their recovery was not related to their stock of recovery capital, a finding contrary to expectations, though once again recovery capital was related to TOP assessments.

Despite these promising findings, as the authors acknowledge, more work is needed before ARC can be accepted as a valid and useful measure for the UK. The originators of the recovery capital concept have stressed the importance of developing "a psychometrically sound instrument that measures one's level of recovery capital" – exactly what the featured study attempted to do – to help treatment providers and policymakers make the most of limited resources. Essentially it would help indicate who is most likely to recover and stay recovered with a relatively low level of support, and who would need much more. But for this purpose, they said just developing a measure would not be enough; it must also be tested in a study which measures recovery capital at one point, and then months or years later, assesses whether it truly did predict recovery from substance use problems. This the featured study was not set up to do. All the relevant measures including the TOP assessment officially mandated as a measure of treatment progress in the UK were taken at one time point, and time in recovery was assessed looking back, not forward. That means (for example) that rather than the social and personal resources which constitute recovery capital promoting long-term recovery, longer recovery durations might offer more opportunity to build those resources – a reversal of the causal direction.

Partly measures recovery itself

Also it is important that a measure seen as helping to cause and predict an outcome does not itself simply measure progress towards that outcome. Someone who has already run a mile is more likely to run two in a given time period than someone still at the starting gate, but we don't normally think of the first mile as causing the second. More useful is to know before the race has started who has the resources to be likely to get to the end without needing a lift or extra training to boost their resources, and who might need both. As the originators described recovery capital, it consisted of generic resources not specific to recovery from substance use. However, the measure tested in the featured study includes elements which rather than assessing an underlying ability to recover, are most straightforwardly interpreted as assessing recovery itself. Among the items most clearly in this category are, "I am making good progress on my recovery journey," and, "I feel I am in control of my substance use," plus other questions in the same domains.

This apparent shortcoming of the measure is exposed by its incompatibility with the understanding of the originators of the recovery capital concept that someone can have what looks like 100% recovery capital, yet still be mired in substance use problems. In fact, some recovery resources such as wealth and status could, they explain, make it easier to remain dependent. However, having maximum recovery capital yet still being actively dependent would be impossible according to ARC's formulation of recovery capital, since to register a maximum score one must agree to being well in to recovery, "completely sober", having experienced no near relapses, not recently intoxicated, and to "regard my life as challenging and fulfilling without the need for using drugs or alcohol". In this respect, its originators' understanding of the relationship between recovery capital and recovery would be impossible if ARC really did measure their concept, showing that on this count it is incompatible with recovery capital as originally conceived.

Another measure relates to problem severity

The featured study related its recovery capital measure to other similar measures, but not to the

severity of substance use problems. All else being equal, the expectation is that among people actually trying to overcome their problems, success will be greatest among those with the greatest recovery capital. This expectation was tested and at least partially confirmed by a study conducted in Scotland, which also developed its own measure of recovery capital. Rather than the yes or no responses required by the featured study, it allowed participants to rate from 1 to 5 the degree to which statements in the scale reflected their feelings about themselves and their communities. The questions extended to their perceptions of the local community's attitudes, the opportunities it provides, and the availability of treatment options and diverse and visible models of recovery.

After preliminary piloting, the 'Recovery Capital Questionnaire' was completed by 98 clients of a publicly-provided recovery support service in Scotland. The same clients also completed a measure of the severity of their substance use and related problems based on the well established Addiction Severity Index, but with additional questions about the ages alcohol and/or drugs had first been used and become problematic, involvement in alcohol- and/or drug-related crime, and cravings for drugs and/or alcohol.

At issue was the degree to which recovery capital predicted the severity of substance use problems, the expectation being that greater capital would tend to mean less severe problems. One limitation of the study was that all the respondents had been in treatment for their substance use and over 60% were 'in recovery' and/or abstinent. All their problem severity scores were relatively low (averaging 11 out of a maximum 120 and peaking at 34), constraining the scope for the recovery capital measure to predict high versus low severity.

Nevertheless, when all the variables were put in to the statistical mix, there was a statistically significant relationship in the expected direction between severity of substance use problems and the recovery capital scale's measure of physical capital – health, sleep, cessation of drug hunger, housing, finances, transport, appearance – and a nearly significant relationship with human capital – self-esteem, efficacy and awareness, values and beliefs, resiliency, problem-solving, hopefulness, life purpose, educational attainment, and perception of past, future, and present. In this analysis, social capital – intimate, family and social relationships, access to sober leisure and recreation outlets, relational roles, family rituals, and emotional support – and the scale's innovative measure of community capital, were no longer significantly related to substance use severity once other forms of capital had been taken in to account.

For the authors, their findings suggest that physical and immediate needs are primary in predicting substance use problem severity, and that bolstering this dimension of recovery capital might help reduce severity. In practice, the findings point to the importance of safe and secure housing, access to training, education, employment and welfare benefits, linkages with health services, support with diet, and substitute prescribing to reduce 'drug hunger'.

However, the relationships were modest and the authors caution that it would be unrealistic to expect a near one-to-one relationship between recovery capital and problem severity. The interacting pattern of the constituents of recovery capital and other more usually assessed factors defy simple rules like 'More recovery capital equals less severe problems'. But even if the predictive value of recovery capital is limited, like the authors of the featured article, they argue that the focusing on assets and strengths entailed in assessing recovery capital can promote recovery.

Like the featured article, the lack of a follow-up assessment precludes conclusions about what if anything caused what in the study, and with no copy of the recovery capital measure included in the article, it is not possible to assess the degree to which it too might have overlapped with measuring recovery itself.

Thanks for their comments on this entry in draft to John Burns of North Ayrshire Council Addiction Services in Scotland. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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